

DIAGNOSING THE AILMENT-- PRESCRIBING THE CURE

**Final Report of the SJR 32 Subcommittee on
Medical Liability Insurance**

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CHAPTER 1: Beginning at the End

Background

Chapter 1 recapitulates the recommendations of the Legislative Council's SJR 32 Subcommittee on Medical Liability Insurance settled upon during the 2003-04 legislative interim. The Subcommittee was created in June 2003 for the sole purpose of conducting the study requested in Senate Joint Resolution No. 32 (2003), i.e., a study of medical liability insurance issues that began to emerge during the 58th Legislative Session.¹ In a nutshell, the issues identified in and to be examined pursuant to SJR 32 included:

- the rising cost of liability insurance for health care providers;
- a significant decline in the past few years in the number of insurance carriers that provide liability insurance for hospitals, clinics, and nursing homes;
- the hypothesis that dramatic hikes in the prices paid by hospitals, clinics, and nursing homes for liability insurance may be a major contributor to the escalation in the cost of providing medical treatment;
- the theory that increased premiums for liability insurance may be forcing physicians and other providers in Montana to consider curtailing certain medical services;
- that the State of Montana has a compelling interest in ensuring that affordable health care is available for its citizens, and a contention that stabilizing premiums for liability insurance for health care facilities and health care providers associated with health care facilities will contribute toward cost containment for health care for Montana citizens.

¹ In the poll of legislators used to determine the relative priorities of all of the studies requested by the 58th Legislature, SJR 32 was ranked the #1 priority.

The study committee was directed by SJR 32 to compile information seen to be relevant by the Legislature and to:

- review measures adopted by other states to address the liability insurance problems related to liability insurance for health care facilities and health care providers associated with health care facilities;
- identify or propose strategies for increasing the availability of affordable liability coverage, including alternative sources of liability coverage;
- identify factors affecting the cost of liability insurance for health care facilities and health care providers associated with health care facilities; and
- identify or develop strategies for resolving liability claims outside of the court system.

Introduction

By one means or another, the Subcommittee pursued information and answers relevant to its mission. The members reviewed numerous reports, monographs, audits, press releases, op-ed pieces, tables, charts, graphs, and the like. They solicited testimony from representatives of hospitals, nursing homes, and other health care facilities. The Subcommittee made special, concerted, and repeated efforts to obtain testimony from health care practitioners--with considerable success. The members also invited the testimony from experts in the medical liability insurance business, including a liability insurance actuary, and again had considerable success. Ample, even copious amounts of information were compiled and made available. However, separating fact from fiction, gaining a complete picture as well as an accurate picture, and determining the truly relevant issues from the spurious remained a constant challenge.

By the end of the Subcommittee's third meeting, January 15, 2004, the members had identified more than 50 ideas and options that they wanted

to learn more about, discuss in more detail or discuss initially after becoming better informed, or in a few cases, perhaps, float as a trial balloon. Staff to the Subcommittee surveyed the members to determine the relative import of the issues as perceived by the members. Of the numerous options, 11 were tagged by the members as worthy of further attention by at least six of the eight members (and only one option was tagged by all eight members). Of the remain 40 ideas, 15 were marked as worthwhile on more than half but by less than three-quarters of the survey forms. The remaining two dozen issues received a designation of deserving further attention on only half or fewer of the survey forms. (See Appendix A for the complete list and the rankings.)

A significant portion of the Subcommittee's fourth meeting was devoted to the members discussing the results of the survey and the relative merits of the ideas and options identified and ranked. The members identified, purely by chance, 10 of the issues as meriting fuller development as draft legislation.

By early June 2004, staff had drafted and distributed the 10 bills to the Subcommittee and the known stakeholders. On June 24, the Subcommittee convened for its final meeting, the focus of which was the 10 draft bills. After a full day's effort, the Subcommittee agreed to recommend eight draft bills to the Legislative Council.

Recommendations

The Subcommittee's recommendations are presented in this report before there is any narrative or documentation that might be construed as a finding or conclusion on which the recommendation is based. The purpose of this approach is to allow the reader to see "the bottom line" without having to sort through material that may or may not be of interest.

That said, however, the reader is strongly encouraged to read the entire report to gain a more complete appreciation of the information provided to and discussed by the Subcommittee.

Recommendation 1: Insurance Reform: LC 5000 This bill establishes the Health Care Liability and Injured Patients Compensation Act, i.e., a state-sponsored, state-mandated reinsurance program for medical malpractice liability insurance (MMLI). In short, hospitals, other health care facilities, doctors, and various other health care providers are required to participate in a reinsurance program--"the plan"--that partially indemnifies the person or entity involved in a civil action for medical negligence.² Indemnification from the plan begins whenever the damages settled upon or awarded exceed \$500,000 in a single instance of medical negligence. The program is modeled on a similar program established in Wisconsin in 1975 that has reportedly been operating successfully since its inception.

As envisioned, a person or entity covered under the plan would carry primary coverage, likely purchased from a private insurer, of at least \$500,000. Any amount of liability incurred for medical negligence exceeding the \$500,000 would be a liability covered by the plan.

The plan is governed by a nine-member board of governors that administers the plan, sets premiums for the reinsurance provided by the plan, oversees the maintenance of accounts for certain victims of medical negligence, and the myriad other elements that compose an insurance plan of this nature.

² "Medical negligence", as used in LC 5000, means a negligent act or omission of a health care provider acting within the scope of the health care provider's employment or profession while providing health care services.

Recommendation 2: Tort Reform: LC 5001 This bill would revise the current status of general liability law, for purposes of a medical malpractice claim, to establish that medical liability may not be imposed on a health care provider for an act or omission by a person or entity claimed to have been an "ostensible agent" of the health care provider at the time that the act or omission occurred. This bill is intended to forestall what some stakeholders view as a possible misinterpretation or misapplication of the policy contained in 28-10-103, MCA. From testimony to the Subcommittee, many doctors who operate, make rounds, or otherwise provide medical services within a hospital, for example, are not employees of but do have "privileges" at the hospital. Under LC 5001 therefore, a non-employee doctor is not an "agent"--ostensible or otherwise--of the hospital, which lack of agency absolves the hospital from any liability for an act of medical negligence or malpractice for which the doctor is responsible. The bill carves out for various health care providers a special immunity from certain liability.

Recommendation 3: Tort Reform: LC 5002 This bill provides that an insurer of medical malpractice liability need not pay and may not be ordered by a court to pay any type of damages, including but not limited to medical expenses and lost wages, prior to a final settlement or a judgment when liability for the act or omission and liability for the damages are reasonably clear.

LC 5002 is intended to preempt what some stakeholders view as a potential application of the reasoning stated in the Supreme Court's decision in the *Ridley* decision.³ In *Ridley*, the Court, overturning the District Court, declared that an automobile liability

³ *Ridley v. Guaranty Nat. Ins. Co.*, 286 Mont. 325, 951 P.2d 987 (1997).

insurer had acted in bad faith because the insurer chose not to pay for the medical expenses or lost wages of the accident victim. Medical liability insurers have become wary that the same rationale may be applied to claims of medical malpractice or negligence, even though reasonable clarity of fault is rare in contested medical liability cases.

Recommendation 4: Tort Reform: LC 5004 This bill was drafted to address what some stakeholders viewed as a misapplication of the "Captain of the Ship" legal doctrine. Some stakeholders proposed LC 5004 as a legislative response to the Supreme Court's decision in *Rudek* case.⁴ The bill achieves a similar objective as LC 5001, i.e., to ensure that only the *de facto* person or entity responsible for alleged medical malpractice is held liable for the malpractice. LC 5004 accomplishes the objective by creating a new section of law that, for purposes of a malpractice claim, immunizes a health care provider from liability for an act or omission by a person or entity that was not an employee or agent of or otherwise under the control of the health care provider at the time that the malpractice occurred. Notably, the new provisions are intended to be codified in Title 27, chapter 7, MCA, which is devoted to "Civil Liability, Remedies, and Limitations: Availability of Remedies -- Liability".

More than a stand-alone provision, LC 5004 combined with the effects of LC 5001 provide a "belt and suspenders" approach to immunizing health care providers from alleged and actual negligent acts of others who are not the providers' agents.

⁴ *Rudek v. Wright*, 218 Mont. 41, 709 P.2d 621 (1985).

Recommendation 5: Tort Reform: LC 5005 This bill revises and clarifies the legal "loss of chance" doctrine as might be applicable under the *Aasheim* decision.⁵ Under *Aasheim*, if an injured person is injured further as a result of medical malpractice and the injured person's chance of recovery is further diminished as a result of the malpractice, the person is awarded the full amount of damages attributable to the malpractice *plus* the amount of damages due to the initial injury.

For example, let us assume that a person has injured her knee in an accident. As a result of the accident, she will have only a 50% chance of recovering her pre-accident use of her knee. Rather than accepting even-odds of full recovery, she chooses, knowing the associated risks of additional injury, to undergo orthopaedic surgery to repair her injured knee. The surgery is not successful, the knee is not repaired, and her chance of recovering full use of the knee has declined to only 15%. She alleges malpractice and asks for damages of \$100,000. Under *Aasheim*, the damages payable to her are the entire \$100,000 determined for the loss of use of the knee--starting from the knee's condition prior to the accident.

In many other jurisdictions, the damages payable as a result of the malpractice would be only 35% of the amount determined for the loss of chance of recovery because her pre-surgery chance of recovery was only 50%. Therefore, in such jurisdictions and under the example, because the woman still has a 15% chance of

⁵ *Aasheim v. Humberger*, 215 Mont. 127, 695 P.2d 824 (1985).

recovery and because her chance of recovery prior to the surgery was only 50%, the damages assessable to the malpractice solely is 35% of the total damages.

LC 5005 statutorily prescribes that calculation for damages for a "loss of chance". Under the bill, damages awarded must be the difference between the percentage chance of recovering prior to the malpractice (50% in the example) and the percentage chance of recovering after the malpractice (15%), multiplied by the total damages (\$100,000). Under LC 5005, the amount of damages payable would be \$35,000, i.e. 35% of the total damages.

Recommendation 6: Tort Reform: LC 5007 This bill establishes as a matter of state policy and the rules of evidence that an act of or words of benevolence from a medical provider cannot be used as evidence in a civil action for medical malpractice.

Testimony revealed that some medical providers, both individuals and institutions, often desire to express an apology, fault, sympathy, compassion, etc., for the pain, suffering, or death of a person in their care. However, in such instances health care providers are typically advised by legal counsel to refrain from such expressions for fear that the expression will be proffered as evidence of an admission of liability. This bill statutorily precludes expressions of sympathy, compassion, or benevolence from being admitted as evidence of admission of liability.

Recommendation 7: Tort Reform: LC 5008 This bill statutorily prescribes the criteria by which a witness can be characterized and sworn as an "expert" in civil actions regarding medical malpractice. Statutorily prescribing criteria is considered to be necessary by

some stakeholders because the Montana Legislature has not enacted a statute defining the qualifications of an "expert witness" in medical malpractice cases. Rather, the Supreme Court has ordered, by Rule, that,

... if scientific, technical, or other specialized knowledge will assist the trier of fact to understand the evidence or to determine a fact in issue, a witness qualified as an expert by knowledge, skill, experience, training, or education may testify thereto in the form of an opinion or otherwise.⁶

This Rule is identical to Federal and Uniform Rules (1974) Rule 702. Montana's Rule states the two common-law standards required before an expert is allowed to give his or her opinion, each of which standards is found in existing Montana law.⁷ Further, a party may through interrogatories require any other party to identify each person whom the other party expects to call as an expert witness at trial, to state the subject matter on which the expert is expected to testify, and to state the substance of the facts and opinions to which the expert is expected to testify and a summary of the grounds for each opinion. (See, Title 25, ch. 20, pt. V, Rule 26(b), MCA.) As written, LC 5008 prescribes for the judge and the court criteria for witnesses seeking expert status in medical malpractice cases only. The qualifications of expert witnesses in all other matters of liability stand to be assessed under Title 25, ch. 20, pt. V, Rule 26(b), MCA, i.e., existing law.

⁶ Ad. Sup. Ct. Ord. 12729, Dec. 29, 1976, eff. July 1, 1977. The Montana Supreme Court adopts, revises, repeals, etc., the Rules of Civil Procedure. Those Rules are published in the MCA *only* as a matter of convenience and courtesy to the Judiciary and the Bar. Because the Rules are within the purview of the Judiciary--much like the Rules of the Legislature are within the purview of the Legislature--the Legislature has been "dissuaded" from attempting to revise, adopting, or repealing the Supreme Court's Rules.

⁷ See "Commission Comments" in Title 26, ch. 10, pt. VII, 702, MCA.

Recommendation 8: Insurance Reform: LC 5009 This bill establishes, under statutorily prescribed conditions, a joint underwriting association consisting of all insurers authorized to write and engaged in writing medical malpractice insurance in Montana. (Comparable statutes were enacted in the late 1970s, in response to the first MMLI crisis.) The purpose of the association is to provide primary medical malpractice insurance to certain health care providers on a self-supporting basis. Each insurer must remain a member of the association as a condition of the insurer's authority to continue to write medical malpractice insurance in Montana. Unlike the reinsurance provided under LC 5000, the joint underwriting association created in LC 5009 is a primary insurer. Finally, the condition under which the association may and must operate is whenever the insurance commissioner determines that medical liability insurance is not available for certain health care providers in the voluntary market. As MMLI again becomes available in the voluntary market, the association must discontinue its underwriting operations.

The Subcommittee members' rationale, as a group or as individuals, for the recommendations is not included as part of this discussion mainly because the rationale is unknown, perhaps even unknowable. Those who are familiar with the legislative process understand that it is foolhardy to speculate as to *why* any one legislator or group of legislators supports or opposes a policy, a bill, an amendment, or anything else on which a vote may be cast. However, reviewing information provided in Chapters 2 and 3 and the appendices that was available to the Subcommittee may provide insight into the Subcommittee's decisions.

Recapitulation of Recommendations

The Subcommittee concluded that establishing a medical liability reinsurance program could help to alleviate increasing prices and decreasing availability of medical liability insurance. In response, the Subcommittee recommends LC 5000, a bill establishing the Health Care Liability and Injured Patients Compensation Act.

The Subcommittee also determined that revising various tort laws was in the interest of Montana. Consequently, the Subcommittee recommends LCs 5001, 5002, 5004, 5005, 5007, and 5008. Respectively, the six bills revise or establish statutes that:

- distinguish, redefine, and clarify the legal doctrine of "ostensible agency" as it applies to medical liability;
- limit any requirement to pay medical expenses and lost wages for medical malpractice prior to a final settlement or a judgment whether or not liability for the malpractice and the damages are reasonably clear;
- distinguish, redefine, and clarify the "captain of the ship" legal doctrine as it applies to medical liability to ensure that only the *de facto* person or entity responsible for medical malpractice is held liable *de jure* for the malpractice;
- prescribes the calculation of damages for a "loss of chance" as the difference between the percentage chance of recovering prior to the malpractice and the percentage chance of recovering after the malpractice, multiplied by the total damages;
- preclude expressions of sympathy, compassion, or benevolence from being admitted as evidence of admission of liability in a civil action for medical malpractice; and
- forge objective, statutory criteria by which a witness can be characterized and sworn as an "expert" in civil actions regarding medical malpractice.

Finally, the Subcommittee determined that the state should create a "safety valve" for certain medical care providers who cannot obtain

affordable MMLI. Accordingly, the Subcommittee recommends reauthorizing a joint underwriting association consisting of all insurers sanctioned to write and engaged in writing medical malpractice insurance. This recommendation is detailed in LC 5009.

CHAPTER 2: Assessing the Medical Liability Terrain

As characterized in SJR 32, the study issues are relatively straightforward: recent experience with and alarm from increasing rates for medical malpractice liability insurance (MMLI); and public policy options potentially available to address the problems identified. Indeed, testimony provided at hearings on SJR 32 noted that some health care facilities had experienced MMLI premium increases on the order of 1,000% or more over the past 2 or 3 years.⁸ Montana is not alone, however, as other states reportedly are experiencing similar circumstances regarding MMLI.⁹

In addition to rising MMLI premiums, medical facilities and medical practitioners have also sounded the alarm that MMLI is becoming increasingly difficult to obtain, at any price, because insurers are leaving the MMLI market. For example, the American College of Physicians points out,

The St. Paul Companies of Minnesota (the nation's second largest medical insurance underwriter), PHICO, Frontier, and Reliance have announced [in 2001] that they would no longer write professional medical liability policies, leaving policies for well over 50,000 physicians and hospitals to expire.¹⁰

⁸ *Minutes*, Senate Judiciary Committee, April 11, 2003, testimony of Senator Duane Grimes.

⁹ See, e.g., *Medical Malpractice Insurance: Multiple Factors Have Contributed to Increases Rates*, U.S. General Accounting Office, June 2003, (GAO-03-702); "Medical Malpractice Reform High On States' Agenda", by Erin Madigan, at Stateline.org; URL www.stateline.org/story.do?storyId=317849, July 29, 2003; "Priority Issue -- Professional Liability Insurance Reform", American Osteopathic Association, URL <http://www.aoa-net.org/Government/stateaffairs/stategov.htm>.

¹⁰ "Professional Liability Reform", American College of Physicians, available on line at URL http://www.acponline.org/hpp/liability_ref.htm.

Nature and scope of the Montana medical liability insurance crisis

SJR 32, in the "whereas" clauses, lays out the basic premises for the resolution and study. In the first clause it states "...many health care providers in Montana are alarmed at the rising cost of liability insurance". In the third clause it states that the number of MMLI insurers "has declined significantly in the past few years". The first statement refers to a price component of the crisis while the second statement refers to an availability component. Each of the components is testable because some MMLI price and availability data are available. Beyond the price and availability components, there is a third component, at least, which is identified in subsections (2) and (4) of the first "resolved" clause: policy options that may be available to Montana's Legislature to address causal factors of the MMLI crisis. Inherent in the third component is a review of steps that Montana has undertaken previously to address similar crises in the past.¹¹

A broader view

Presenting a multistate viewpoint, the Council of State Governments (CSG) has recently published a report that characterizes the crisis somewhat differently from SJR 32. As CSG reports it,

Medical malpractice is a three-pronged problem. First, there are the medical care providers whose mistakes lead to medical malpractice claims. Second, the legal system requires a great deal of time, effort and money to determine fault, so it's an inefficient means of settling malpractice claims. Third, the medical malpractice insurance

¹¹ The SJR 32 Subcommittee on Medical Liability Insurance began to examine policy options at its meeting of November 15, 2003. The 54th Legislature (1995) adopted an array of "tort reforms" that resulted, in part, from a study conducted during the 1993-94 interim. See *Medical Malpractice and Tort Reform: Issues of Insurance Costs, Coverage, Caps and Compensation*, Montana Legislative Council, pub., December 1994.

industry raises and lowers premiums, not based on a physician's track record, but partly on the ups and downs of the national economy.¹²

Certain information regarding medical practice, the legal environment, and the MMLI industry was examined independently and interdependently. Some of the information was readily available, but only some.¹³ Therefore, the Subcommittee found and the Legislative Council may find it difficult to reach consensus findings and, in particular, consensus conclusions that can be vigorously supported with data and empirical evidence.

Laying a foundation

Proposing a solution before identifying the problem to be solved is generally not a good idea. A rational place to begin the study of MMLI was to establish whatever factual information can be established. However, it is doubtful that "facts" alone were sufficient for the Subcommittee to reach meaningful findings and conclusions and the same holds for the Legislative Council. As evidence, a legislative staffer from California, a state that has a long history of public policy interaction with medical malpractice issues, characterizes his experience and observation quaintly:

... the med mal issue is characterized by absolutely contradictory information by both sides, and sorting out the reality and fact is difficult.

John Miller, Staff, California Senate Office of Research

¹² *Medical Malpractice Crisis*, Council of State Governments, Lexington, KY, April 2003 (revised May 2003), p.1.

¹³ *Medical Malpractice Insurance: Multiple Factors Have Contributed to Increases Rates*, U.S. General Accounting Office, June 2003, pp. 22, 45,. (GAO-03-702); *Medical Malpractice: Implications of Rising Premiums on Access to Health Care*, U.S. General Accounting Office, August 2003, p. 17-21. (GAO-03-836)

The literature seems to support Miller's contention.¹⁴ Consequently, the reported facts will, first, have to be understood within the context of their origins, i.e., the age-old who, what, what, when, where, why and how. Second, policymakers and others must determine how those facts may relate to public policy options for Montana.

The insurance component of the crisis

A cost crisis

It was and remains difficult to establish the breadth and depth of the MMLI cost crisis in Montana. Understandably, it would be alarming for a hospital administrator to see the MMLI premium for his or her facility increase from \$9,000 in one year to \$90,000 only 2 years later or from \$8,000 to \$66,000 in a similar time frame.¹⁵ What these two examples don't disclose, unfortunately, are any other factors that may have affected the changes in premiums.

Aggregated data for Montana showed that the total net premiums for MMLI in Montana rose from about \$16.95 million in 1998 to \$22.89 million in 2002.¹⁶ More current information shows net premiums for 2003 at \$26.74 million.¹⁷ At \$9.8 million or 58% (nominal) over the 6-year period,

¹⁴ See, e.g., "Beyond MICRA: New Ideas for Liability Reform", American College of Physicians, on line at URL <http://www.acponline.org/hpp/pospaper/micra.htm>, undated; "The Impact of Medical Malpractice Insurance and Tort Law on Washington's Health Delivery System", Washington State Medical-Education and Research Foundation, September 2002; "Confronting the Myths on Medical Liability Reform", American Medical Association, position paper, undated; "MICRA vs. Prop. 103", American Medical Association, position paper, undated; *The Medical Malpractice Insurance Crisis: Opportunity for State Action*, by Mimi Marchev, National Academy for State Health Policy, July 2002; *Premium Deceit: The Failure of "Tort Reform" to Cut Insurance Prices* by J. Robert Hunter and Joanne Doroshow, Center for Justice and Democracy, Washington, DC, 2002.

¹⁵ Testimony of John Flink, Montana Hospital Association, *Minutes*, Senate Judiciary Committee, April 11, 2003.

¹⁶ From "1998-2002 Detail Business in the State" (series) , State Insurance Commissioner, Helena, MT.

¹⁷ "2003 Detail Business in the State", State Insurance Commissioner, Helena, MT.

the increase is notable. Even after run-of-the-mill inflation is factored in at approximately 2.5% annually over the 6-year period, the "real" or "inflation-adjusted" change in net premiums would be about \$7.55 million or 45% over the period. Stated differently, the annual increase in total MMLI net premiums in inflation-adjusted terms from 1998 through 2003 would be about 9.5% per year.¹⁸

An availability crisis

With respect to the MMLI availability component, the announcement in December 2001¹⁹ of the St. Paul Companies' departure from the MMLI marketplace has been cited as a significant development in the MMLI market, markedly significant in some states and relatively significant nationwide.²⁰ Through 2002, however, St. Paul's departure from the market did not appear to have been that significant for Montana as a whole--at least not yet.

In 1998, for example, the St. Paul Companies accounted for about 12.5% of MMLI net premiums reported in Montana.²¹ By 2002, the St. Paul Companies share had declined to about 8.3% of MMLI net premiums,²² then to about 2.7% of net premium in 2003.²³

¹⁸ The 9.5% annual inflation in premiums is nearly 50% higher than long-term (>25 years) medical inflation of approximately 6.7%. (Staff estimate from Exhibit 3 in *Stable Losses/Unstable Rates 2003*, Americans for Insurance Reform, November 2003, p. 7.) See also, "Commentary: A Second Opinion on the Malpractice Plague", by Lorraine Woellert, BusinessWeek online, March 3, 2003, in which the *Journal of Health Affairs* is cited as the source of medical inflation of 6.7% from 1990 to 2001.

¹⁹ "The St. Paul Companies, Inc. Exits Certain Businesses", (December 12, 2001) in Key Developments at MSN Moneycentral, <http://news.moneycentral.msn.com/ticker/sigdev.asp?Symbol=spc>

²⁰ See *The Medical Malpractice Insurance Crisis: Opportunity for State Action*, by Mimi Marchev, National Academy for State Health Policy, July 2002, p. 6. (esp. footnote no. 14.)

²¹ "1998 Detail Business in the State: Medical Malpractice", State Insurance Commissioner, Helena, MT.

²² "2002 Detail Business in the State: Medical Malpractice", State Insurance Commissioner, Helena, MT.

²³ "2003 Detail Business in the State: Medical Malpractice", State Insurance Commissioner, Helena, MT.

From a statewide perspective of MMLI availability, available data showed that there were 56 insurers offering MMLI in Montana in 1998, with 40 of them actually reporting net premiums. By 2002, the number of insurers offering MMLI had actually increased to 57, with 38 of them reporting net premiums from MMLI, and by 2003, 60 insurers offered MMLI and 39 reported net premiums. Over the 6-year period, the number of MMLI insurers licensed and reporting net premiums in Montana remained essentially constant.²⁴ These figures directly contradict the statement in SJR 32, "the number of insurance carriers that provide liability insurance for hospitals, clinics, and nursing homes has declined significantly in the past few years".

The severity of the crisis in Montana

One factor that called into question the severity of the MMLI crisis in Montana was a then-recent report (August 2003) from the U.S. General Accounting Office. As stated in the audit report,

In the absence of reliable national sources of data concerning provider responses to rising malpractice premiums, we focused our review on nine states selected to encompass a range of malpractice premium pricing and tort reform environments. Five of these states [FL, MS, NE, PA, WV] were among those cited by AMA and other national health care provider organizations as malpractice "crisis" or "problem" states based on such factors as higher than average increases in malpractice insurance premium rates, physicians' reported difficulties obtaining malpractice insurance coverage, and reports of actions taken by providers in response to the malpractice-

²⁴ "Detail Business in the State" (1998-2002 series) , State Insurance Commissioner, Helena, MT.

related pressures of rising premiums and litigation. The remaining four states [CA, CO, MN, **MT**] were not cited by provider groups as experiencing malpractice-related problems.²⁵ (*Emphasis added.*)

Assuming that the GAO auditors correctly compiled and accurately reported their findings, at least the Montana Medical Association and some other Montana health care providers did not view Montana as a state contending with an MMLI crisis.²⁶

Factors contributing to increased premium rates

To the extent MMLI premium rates and availability are resulting in a crisis across Montana or only in scattered localities or within certain medical specialties only, there are certain factors that may be causing the circumstances. For example, the U.S. General Accounting Office notes four separate categories of factors that contribute to changes in premium rates.

Insurers' losses, declines in investment income, a less competitive climate, and climbing reinsurance rates have all contributed to rising premium rates. First, among our seven sample states, insurers' losses have increased rapidly in some states, increasing the amount that insurers expect to pay out on future claims. Second, on the national level insurers' investment income has decreased, so that insurance companies must increasingly rely on premiums to cover costs. Third, some large medical malpractice insurers have left the market in some states because selling policies was no longer profitable, reducing the downward competitive pressure on premium

²⁵ *Medical Malpractice: Implications of Rising Premiums on Access to Health Care*, U.S. General Accounting Office, August 2003, p. 3. (GAO-03-836). The five states with reported (MMLI) problems are Florida, Mississippi, Nevada, Pennsylvania, and West Virginia. The four states without reported (MMLI) problems are California, Colorado, Minnesota, and Montana.

²⁶ The "other entity" providing information on the cost/availability components in Montana was the Association of Montana Health Care Providers. (See *Medical Malpractice: Implications of Rising Premiums on Access to Health Care*, U.S. General Accounting Office, August 2003, App. I, p. 42. (GAO-03-836).)

rates that existed through most of the 1990s. Last, reinsurance rates for some medical malpractice insurers in our seven sample states have increased substantially, increasing insurers' overall costs. In combination, all the factors affecting premium rates and the availability of medical malpractice insurance contribute to the medical malpractice insurance cycle of hard and soft markets.²⁷

Insurers' losses are, in a nutshell, the amount of net premium, investment, and other income taken in by an insurer minus the amount of claims paid out by the insurer over the same time period. Several studies have found that these losses are the primary contributor to higher MMLI premiums.²⁸

There are many variables that must be accounted for within the loss equation. To complicate matters, the ways in which changes in premiums, investment and other income, and claims paid and claims incurred interact vary among insurers, jurisdictions (both individual states and within any given state), different practices or specialties, different facilities, etc. Additionally, the numerous variables can be directly or indirectly affected by various economic, demographic, scientific, technological, cultural, legal, and other influences.

Declines in investment income, the second factor cited, depends on numerous subfactors, including the type of insurer, the amount of investable principle, rates of return, duration of investment of principle, etc. For example:

- a "mutual insurance company" may not have access to the same types of investable capital that a publicly-traded insurance company has access to;

²⁷ See, e.g., *Medical Malpractice Insurance: Multiple Factors Have Contributed to Increases Rates*, U.S. General Accounting Office, June 2003, p. 15. (GAO-03-702)

²⁸ Ibid.

- when an insurer has large amounts of investable capital, it has investment options, e.g., certain privately placed bonds, convertible bonds, etc., that realistically are not options for insurers with less investable capital;
- a riskier investment typically carries a higher rate of return, but a company with a weak balance sheet cannot prudently accept the higher risk even when the anticipated return is also higher. An insurer with a strong balance sheet may be able to prudently invest in some higher-risk instruments without jeopardizing its solvency.
- longer-term fixed investments, including bonds, money markets, etc., typically have higher returns than comparable shorter-term fixed investments. An insurer with a strong balance sheet may prudently invest in longer-term, higher-return fixed instruments without unduly affecting viability; an insurer with a weaker balance sheet may not have the same luxury.
- when the stock market is healthy, the bond market is not. Perhaps counter-intuitively, a weak bond market means that rates of return on debt instruments are higher than when the bond market is strong. Insurers rely primarily on debt instruments²⁹, such as bonds, as investments and those types of investments generated relatively high returns during the 1990s. As the stock market bubble burst in early 2000, the bond market began to rally and fixed-investment returns to insurers began to decline.

Unquestionably, there are other factors that can affect investment income. Understanding each of the (major) factors and how each of the factors interact, both for the MMLI industry as a whole and for individual insurers, is necessary to understand how the investment income factor can affect MMLI premiums.

²⁹ Ibid., p. 4.

The third factor, a less competitive climate, is a result of other factors as well, including a reduction in the numbers of available MMLI insurers. With less competition, it is easier for any of the remaining insurers to increase premium rates. Fewer providers in the MMLI market can occur for various reasons, including nonprofitability of the departed insurer's MMLI insurance line, an insurer's insolvency (bankruptcy), industry consolidation (mergers and acquisitions), etc. However, available data (2003) do not support the contention that there are fewer insurers in Montana.³⁰

Finally, the cost and availability of reinsurance also affects the pricing of MMLI. Reinsurance is insurance for insurers. Insurers purchase reinsurance to spread the risk of claims or losses in excess of those initially anticipated by the insurer.³¹ Whenever an "input" cost, such as reinsurance, of the MMLI premium increases, the MMLI premium must also increase if the profitability of the insurer or at least an insurance line is to be maintained.

The medical system component of the crisis

Without real and alleged malpractice by medical practitioners and medical facilities, there would be no need for MMLI and, hence, there would be no MMLI crisis. But medical errors do occur and those errors are sometimes the result of malpractice. As reported by the organization Public Citizen,

³⁰ "Detail Business in the State" (1998-2003 series) , State Insurance Commissioner, Helena, MT.

³¹ Some insurers not only purchase reinsurance but also sell reinsurance. Thus, the effects of major casualties, e.g., Hurricane Andrew or the events of September 11, 2001, can have considerable impact on the overall profitability of a given insurer. Notable, for example, the St. Paul Companies were reinsurers affected by 9/11/01.

According to the Institute of Medicine (IOM), which completed a comprehensive report on the medical malpractice issue in 1999, medical errors "are a leading cause of death in the United States.... At least 44,000 and perhaps as many as 98,000 Americans die in hospitals each year as a result of medical errors. Deaths due to preventable adverse events exceed the deaths attributable to motor vehicle accidents (43,458), breast cancer (42,297) or AIDS (16,516)."³²

The medical community, insurance companies, injured parties and others would prefer that malpractice did not occur at all. Because it does, however, the ways in which the medical community is "regulated" or "policed" may have implications for MMLI rates and availability and for public policy options.

The legal system component of the crisis

If doctors, hospitals, insurers, attorneys and other stakeholders in the MMLI crisis can agree on anything, it would probably be that truly injured parties deserve just compensation for the injury. But the devil is in the details and whatever agreement might exist initially often ends quite abruptly.

Disbelief is probably as good a description as any of the initial reaction many people have when they hear of a case in which the injured party reportedly receives an award that is seemingly exorbitant given the reported extent of the injury. A second reaction may be disillusionment with a legal system or process that concludes with a seemingly irrational result, for example, the often-reported McDonald's coffee case.³³

³² *Florida's Real Medical Malpractice Problem: Bad Doctors and Insurance Companies Not the Legal System*, Public Citizen, Washington, D.C., 2001, p. 3. (Originally from Institute of Medicine, *To Err is Human: Building a Safer Health System*, Washington D.C., National Academy Press, 1999, p. 26.)

³³ "The 'McDonald's Coffee Case' and Other Fictions", Center for Justice and Democracy, NY, NY, undated. This case involved a woman who had spilled a cup of McDonald's coffee in her lap. It was initially and repeatedly reported that she had been awarded \$3 million for the mishap, i.e., \$200,000 in

As frequently derided as it is whenever associated with medical malpractice liability, the legal system comes into the picture only if an injured party believes that his or her injury is the result of malpractice and, subsequently, that adequate compensation for the injury is not forthcoming without resorting to legal means. Instances of malpractice for which claims are made are in the significant minority, however. Specifically with respect to injury as a result of medical malpractice, estimates of the number of claims filed range from about 1 claim for every 6 injuries³⁴ to 1 claim for every 8 injuries.³⁵ Additionally, estimates of the likelihood that a claim results in compensation to the plaintiff range from about 1 in 2 to 1 in 4 of the claims filed.³⁶

Differences of experience and opinion

In addition to the issue of the frequency of claims made for medical malpractice is the related issue of the severity of claims. In a 2002 study commissioned by the U.S. Department of Health and Human Services, the need for tort reform at the national level is seen as crucial.

... Increasingly, Americans are at risk of not being able to find a doctor when they most need one because the doctor has given up practice, limited the practice to patients without health conditions that would increase the litigation risk, or moved to a state with a fairer legal system where insurance can be obtained at a lower price.

compensatory (actual) damages and \$2.7 million in punitive damages. Penultimately, the judge reduced the award to approximately \$640,000, i.e., \$160,000 actual and \$480,000 punitive. Subsequently, the parties entered a post-verdict settlement.

³⁴ *Florida's Real Medical Malpractice Problem: Bad Doctors and Insurance Companies Not the Legal System*, Public Citizen, Washington, D.C., 2001, p. 4.

³⁵ *Medical Malpractice: Perceptions and Misperceptions*, American Bar Association, Feb. 1995, p. 8. One report on MMLI suggests that the likelihood of compensation being paid to an injured party may be as remote as 3%, i.e., only 3 of 100 injured parties actually receive compensation. (*Medical Malpractice Crisis*, Council of State Governments, April 2003, p. 9.)

³⁶ See, e.g., *The Medical Malpractice Insurance Crisis: Opportunity for State Action*, by Mimi Marchev, National Academy for State Health Policy, July 2002, p. 3.

This broken system of litigation is also raising the cost of health care that all Americans pay, through out-of-pocket payments, insurance premiums, and federal taxes. Excessive litigation is impeding efforts to improve quality of care. Hospitals, doctors, and nurses are reluctant to report problems and participate in joint efforts to improve care because they fear being dragged into lawsuits, even if they did nothing wrong.

Increasingly extreme judgments in a small proportion of cases and the settlements they influence are driving this litigation crisis. At the same time, most injured patients receive no compensation.³⁷

Similar to other aspects of the crisis, there is fundamental disagreement about historical and recent changes in the severity of claims. For example, the U.S. General Accounting Office states:

... the average reported claims payment made on behalf of physicians and other licensed health care practitioners in 2001 was about \$300,000 for all settlements, and about \$500,000 for trial verdicts.³⁸

BusinessWeek online, an affiliate of *Business Week* magazine, gives a second opinion on the tort reforms being discussed at the national level:

... The size of damage claims paid out by physician insurers has been more or less steady since 1991, according to the National Practitioner Data Bank, a government service that tracks doctor errors and malpractice claims. The mean payout was \$135,941 in 2001, up 8.7% from \$125,000 a year earlier. Over 10 years, malpractice payouts have grown an average of 6.2% a year.

Guess what? That's almost exactly the rate of medical inflation: an average of 6.7% between 1990 and 2001, according to the *Journal of Health Affairs*. It's also worth noting that, nationwide,

³⁷ *Confronting the New Health Care Crisis: Improving Health Care Quality and Lowering Costs By Fixing Our Medical Liability System*, U.S. Department of Health and Human Services Office of the Assistant Secretary for Planning and Evaluation, July 24, 2002, p. 1. On line at URL <http://aspe.hhs.gov/daltcp/reports/litrefm.pdf>

³⁸ *Medical Malpractice: Implications of Rising Premiums on Access to Health Care*, U.S. General Accounting Office, August 2003, p. 8. (GAO-03-836).

malpractice payouts by physicians and their insurers were a mere \$4.5 billion in 2001--less than 1% of the country's overall health-care costs of \$1.4 trillion. They have risen slowly, if steadily, since 1996, when the total was \$3.5 billion.³⁹

The American Osteopathic Association asserts:

[A] report by Jury Verdict Research has shown that jury awards and verdicts doubled from 1995 to 2000. The median award in 1995 was \$500,000. Six years later in 2001 (the latest figure available), the median award was \$1 million, after increasing by more than 40 percent in 2000.⁴⁰

On the same topic, Weiss Ratings, Inc.⁴¹, offers its opinion:

The median payout in states without caps surged 127.9 percent, from \$65,831 in 1991 to \$150,000 in 2002. In contrast, the median payout grew by 83.3 percent in states with caps, from \$60,000 to \$110,000. Likewise, in states without caps, the median payout for the entire 12-year period was \$116,297, ranging from \$75,000 to \$220,000, while the median payout for states with caps was 15.7 percent lower, or \$98,079, ranging from \$50,000 to \$190,000.⁴²

And, finally, from Americans for Insurance Reform:

³⁹ "Commentary: A Second Opinion on the Malpractice Plague", by Lorraine Woellert, *BusinessWeek online*, March 3, 2003.

⁴⁰ *Priority Issue: Professional Liability Insurance Reform*, AOAnet, no author or date. On the internet at URL <http://www.aoa-net.org/Government/stateaffairs/stategov.htm>.

⁴¹ Weiss Ratings, Inc., according to its website, evaluates "the financial stability of over 16,000 financial institutions, including banks, insurance companies, HMOs, and securities brokers. Weiss also rates the risk-adjusted performance of over 12,000 mutual funds including stock funds, bond funds, and money market funds, and over 9,000 common stocks." Source: http://www.libraryresource.com/entries/weiss_ratings_inc.,insurance.shtml

⁴² "Medical Malpractice Caps Fail to Prevent Premium Increases", Weiss Ratings, Inc., June 3, 2003, on line at URL http://weissratings.com/News/Ins_General/20030602pc.htm. NOTE: Montana has had the AMA-recommended cap on noneconomic damages, \$250,000, since 1995.

New insurance industry data and analysis...shows that the average medical malpractice insurance payout, or closed claim, has been only \$28,524 over the last decade. Payouts in 2001 follow the same low pattern. This figure includes all jury verdicts, settlements and other costs used by insurers to fight claims in court. Moreover, medical malpractice insurers are paying nothing in 77 percent of all claims filed; in the 23 percent of cases where insurers pay anything, the average claim is only \$107,587. According to the Harvard Medical Practice Study, only one in eight malpractice victims ever files a claim for compensation.⁴³

Searching for causal factors

Identifying the specific cause or causes of rising premiums is, at best, elusive. On the one hand, representatives of medical facilities and medical providers and various insurers have identified the costs of tort actions, both those that are settled and those that are litigated, as a primary driver in spiraling MMLI costs.⁴⁴ In one release, the American Medical Association leaves few questions about its position:

Today's report also puts to rest two other trial lawyer smokescreens: that insurance company gouging and/or stock market losses have caused the medical liability crisis. Today's report makes clear that bonds make up 80 percent of insurers' investments and that 'no medical malpractice insurers experienced a net loss on their investment portfolios.' The GAO report also states that insurer 'profits are not increasing, indicating that insurers are not charging

⁴³ "New Study Shows Average Medical Malpractice Payout over Last Decade Only \$28,524; New Data Reveals Same Trends in 2001", Americans for Insurance Reform, January 23, 2003, on line at URL <http://www.centerjd.org/air/pr/release030123.html>.

⁴⁴ "Warning to Senate Judiciary Committee to Curb Medical Liability Excesses", American College of Physicians, on line at URL http://www.acponline.org/hpp/liability_excess.htm.

and profiting from excessively high premium rates.' It also notes that insurance regulators in most states have the authority to deny excessive premium rates.⁴⁵

The American Tort Reform Association, a compatriot of the AMA, apparently holds similar views:

The fact is that medical malpractice insurance premiums have skyrocketed because both the frequency and severity of claims are on the rise.⁴⁶

And the American Academy of Dermatology Association echoes the sentiment:

The root cause of this problem [*rising premiums*] is the unrestrained escalation of jury awards and settlements. These awards and settlements are driving up liability insurance premiums for physicians, including dermatologists, and are forcing insurance companies out of the business of providing medical liability insurance.⁴⁷

On the other hand, the contingent of the Bar often referred to as trial lawyers has a distinctly different perception of the causes of rising rates, particularly as malpractice awards or malpractice litigation in general are characterized as direct "causes" of the MMLI crisis.

⁴⁵ "Increasing lawsuit awards are the main cause of skyrocketing liability insurance rates", attributed to Donald J. Palmisano, MD, AMA President, July 28, 2003. URL www.ama-assn.org/ama/pub/article/1617-7913.html. The "report" referred to in the statement is a report prepared by the U.S. General Accounting Office, *Medical Malpractice Insurance: Multiple Factors Have Contributed to Increases Rates*, U.S. General Accounting Office, June 2003, (GAO-03-702).

⁴⁶ "John Edwards Botches the Facts on Medical Liability", American Tort Reform Association, May 23, 2003 on line at URL <http://www.atra.org/show/7568>.

⁴⁷ "Medical Liability Reform Talking Points", American Academy of Dermatology Association, Gov't Affairs, 2003, on line URL http://www.aadassociation.org/Medical_Liability_Reform_TP.html

Investment income is down, and as a result, the insurance industry is now charging higher medical malpractice premiums. The American Medical Association (AMA) is calling for federal legislation that preempts state medical professional liability laws to limit compensation to patients injured by malpractice because the AMA assumes such limits will reduce malpractice rates. However, there is no evidence that limiting compensation to injured patients will have a real impact on malpractice rates. The AMA is carrying on a multi-million dollar public relations campaign to gain public support for such federal legislation and for tort law changes at the state level.

... The ABA urges the legal and medical professions to cooperate in seeking a solution to medical liability problems and maintains that federal involvement in the area is inappropriate. In particular, the ABA opposes caps on pain and suffering awards, supports retaining current tort rules on malicious prosecution, collateral sources and contingent fees, and believes that the use of structured settlements should be encouraged. It also supports certain changes at the state level in the areas of punitive damages, jury verdicts and joint and several liability.⁴⁸

The ABA's perception is apparently shared by researchers at the Center for Justice and Democracy:

... *[research]* indicates that there is a modest rise in insurance rates/loss costs from the adoption of mid-range tort reforms for the Medical Malpractice category. That is, the underlying costs, which ultimately drive insurance prices, are impacted *upwardly* by mid-range medical malpractice tort law changes of the type adopted in this nation since the liability insurance crisis of the mid-1980s. This is counter-intuitive. While there does appear to be a reduction in rates/loss costs from severe tort law changes in medical malpractice... the mixed results confuse any conclusion. One reasonable conclusion is that no clear evidence of tort law change impacting insurance prices is determinable from these data.... Indeed, there is no evidence that general, across-the-board "tort reform" (or product liability "tort reforms") has lowered insurance rates/loss costs.⁴⁹ (Emphasis in original.)

⁴⁸ "Tort Law: Medical Professional Liability", 2003 Legislative Priorities, American Bar Association, July 23, 2003, on line at URL <http://www.abanet.org/poladv/priorities/mpl.html>.

⁴⁹ *Premium Deceit: The Failure of "Tort Reform" to Cut Insurance Prices* by J. Robert Hunter and Joanne Doroshow, Center for Justice and Democracy, NY, NY, 2002, pp 17-18.

As if the disagreement between the tort reformers and the insurance reformers wasn't sufficiently confusing, testimony to and information distributed to the Subcommittee by the Montana Medical Legal Panel staff provided some downright confounding information and insights. In his testimony to the Subcommittee,⁵⁰ Gerald Neely, Esq., referred to his findings from a Fall 2003 survey of the membership of the Montana Medical Association and labeled some of his findings as "new and startling information", including:

- the new information revealed that the bulk of the physicians and hospitals, in essence, "own" their own insurance carriers. He said he didn't have exact percentages but he estimated more than 70% of Montana physicians are insured by their own carriers. This creates, in his opinion, a contradiction in the medical malpractice liability insurance issue and a question of why there has been no discussion on these self-insured programs.

- The focus and concern must be on these carriers who represent the bulk of the hospitals and physicians, and where are they in the percentages.

- Another crucial factor is the notion held by some that there has been a significant increase in the claims made in Montana. This has been totally contrasted by the testimony, witness after witness, that physicians and facilities have not experienced a rise in the number of claims. Mr. Neely stated, "The fact of the matter is that Montana has an absolute recent decline in the number of claims per physician." There is one source of data for this information, which is the Montana Medical Legal Panel. Mr. Neely said, to his knowledge, there was no contrary authority published anywhere in the United States that indicates that the rate of claims in Montana has increased. The National Practitioner Data Bank... doesn't collect information on the rate of claims, only information on the rate of paid claims.

- Per 1000 physicians, in an absolute sense, the rate of claims and the rate of cases filed are both diminishing in Montana. In 2000, Montana had a total of 93 paid claims, as reported by the National Practitioner Data Bank. In 2001, Montana had 67 paid claims and in 2002, Montana had 69 paid claims. Mr. Neely said if the number of claims paid in Montana is divided by the number of people in Montana, and if that number is compared with the

⁵⁰ The statements attributed to Gerald Neely are taken from the *Minutes*, SJR 32 Subcommittee on Medical Liability Insurance, Nov. 17, 2004, pp. 13-16. The author exercised editorial license to make a few of Mr. Neely's statements more readable, without changing the statements' substance.

same number from other states, the rate of paid claims in Montana is high but not in absolute numbers; only in dollars paid out on those claims.

- In Montana, there is a lower number of absolute claims, a lower rate of claims and rate of paid claims, and there have only been three claims paid out in excess of \$1 million from 1995 through the current year [2003 November].⁵¹

- [according to] the data of the Utah Medical Insurance Association and the data from The Doctor's Company, a large loss problem is not indicated. Mr. Neely said he knew for a fact that, according to the UMIA rate card, premium rates were only increased 25% last year and that The Doctor's Company had actually reduced premiums in some specialties. He said he found it puzzling that doctors had reported such huge increases in insurance premiums, in light of this information, and said the testimony heard last night and today did not "square" with the insurance company information.

- Data show that 25% of Montana doctors have coverage in excess of \$2 - \$4 million and 30% have \$1 - \$3 million. The doctors are overpaying because the claims history doesn't support the need for this level of coverage.

Perhaps not surprisingly, Dr. Kurt T. Kubicka, on behalf of the Montana Medical Association, took issue with Mr. Neely's findings and testimony from November 2003. In a letter to the Subcommittee, Dr. Kubicka noted broad-based premium rate increases of 25% in each of 2003 and 2004, one major medical liability insurer who anticipates incurring losses of "\$1.38 for every dollar of premium received", and current conditions that are "worsening and accelerating".⁵²

⁵¹ The statement regarding "3 claims in excess of \$1 million" was presumably accurate when it was made in Nov. 2003. However, it is now reported that there have been 4 such claims paid. See *Year 2004 Montana Medical Legal Panel Report*, G. Brian Zins, Montana Medical Legal Panel, Feb. 27, 2004, p. 8.

⁵² See letter to SJR 32 Subcommittee on Medical Liability Insurance, January 13, 2004, from Kurt. T. Kubicka, M.D., President, Montana Medical Association, in *Minutes*, SJR 32 Subcommittee on Medical Liability Insurance, Jan. 15, 2004, as Exhibit #15.

CHAPTER 3: Examining Montana's and Other States Medical Liability Laws

State policy makers have various options that may or may not affect MMLI premiums. For Montana policy makers, some of those options were visited in previous MMLI crises in the 1970s and 1980s and, most recently, revisited in the 1993-94 interim. In 1995, the 54th Legislature enacted some of the options⁵³ that, today, are being strenuously advocated and, simultaneously, strenuously resisted at the national level. In the spirit of the SJR 32 direction to review measures adopted by other states to address the liability insurance problems, the Subcommittee was presented with then-recent action in Florida that had included examining MMLI options considered by other states. In Florida, the Governor's Select Task Force on Health Care Professional Liability Insurance ultimately made 60 recommendations distributed across five categories.⁵⁴

Using the Florida categories as a broad outline, numerous elements remained within the category of establishing a factual foundation of MMLI in Montana and the Subcommittee considered examining the same or similar broad categories.

Healthcare quality. Had this category become a focus, various statistical and other information would have been compiled and analyzed regarding the nature and scope of medical malpractice in Montana. Included in this category might be an examination of the law and practice regarding the reporting of medical errors, both committed and observed;

⁵³ See House Bill No. 309, Ch. 461, Laws of Montana 1995.

⁵⁴ *Governor's Select Task Force on Healthcare Professional Liability Insurance*, final report, pp. vii - xvi.

various patient safety initiatives; health care or patient safety "demonstration projects"; reviewing statutory or other requirements for patient safety in medical facilities; within the insurance code, potential changes intended to reduce MMLI premiums; and educating the public on health care. This category of information was not pursued by the Subcommittee.

Physician discipline. Examining this category would have involved compiling and reviewing statistical and other information on the extent to which medical errors are committed, observed, and reported and that might be preventable. Subcategories might have included quasi-judicial review initiatives; clarifying the scope of regulatory or licensing authorities regarding standards of care; the establishment or codification of standards of care; periodic independent review of physician discipline; the confidentiality of certain, particularly sealed, records regarding medical error; physician profiles; mediation initiatives; burden of proof requirements in disciplinary proceedings; and use of the Internet to promote and ensure systemic integrity. This category of information was not pursued by the Subcommittee.

The need for tort reform. Topics falling under this rubric included measuring the effects of existing "tort reforms" enacted previously in Montana or elsewhere; visiting or revisiting the efficacy of previously adopted or considered reforms; various aspects of civil procedures regarding medical malpractice claims; qualifications of expert witnesses; liability for emergency services; sovereign immunity from medical malpractice under certain circumstances; payment of damages; pre-lawsuit initiatives; and plaintiff attorney fees.

Considerable material and testimony relevant to this category was provided by various stakeholders which may have influenced the Subcommittee's requests of staff to compile and provide additional

information relevant to "tort reforms". In fact, much of the Subcommittee attention was devoted to identifying additional tort reforms that could, potentially, mitigate the MMLI price and availability problems.

Alternative dispute resolution. This category would have included reviewing such alternatives as mandatory mediation models or voluntary binding arbitration initiatives. Although there was some interest in arbitration alternatives, the fact that Montana has had the Montana Medical Legal Panel since 1977 seemed to make further examination of the topic largely unnecessary. Nevertheless, the Subcommittee entertained discussion of at least one proposal to substantially revise the Montana Medical Legal Panel Act. No recommendation is made in regard to the Panel.

Insurance reform. Included under this heading might have been such matters as bad faith; alternative insurance products; and insurance company regulation. Although the Subcommittee did not scrutinize all aspects of this category, the Subcommittee's recommendations reveal that certain insurance reforms, reforms that are not "tort reform" related, were seriously considered.

In order to maximize the likelihood of the Subcommittee achieving successful outcomes from the SJR 32 study, the members exerted their attention on the nature and scope of the crisis *in Montana*,⁵⁵ but did so while simultaneously reviewing what was going on elsewhere. During the summer of 2003 and continuing through May 2004, the Subcommittee's staff compiled and provided to the Subcommittee information comparing

⁵⁵ Although the Subcommittee did not articulate a consensus on the causal relationships between various factors and the MMLI crisis in Montana and, subsequently, on the ability of state policy makers to effect positive changes in the causal factors in Montana, the recommendations suggest that there was at least some level of agreement, particularly in the areas of additional tort reforms--as evidenced by LCs 5001, 5002, 5004, 5005, 5007, and 5008--and alternative insurance products--as evidenced by LCs 5000 and 5009.

states' medical liability environments and legal liability reforms. The two most comprehensive compilations of liability environments and reforms were developed, independently, by the National Conference of State Legislatures (NCSL) and the American Medical Association (AMA). Each of the compilations covers all 50 states and there is some overlap among the legal or reform categories included. However, there are also categories unique to each collection.⁵⁶ The two documents provided much of the information repeated or summarized in this chapter.

Two specific areas of legislative interest characterized in SJR 32 were the recent experience with and alarm from increasing rates for MMLI and the public policy options potentially available to address the perceived price and availability problems.

This installment of the report focuses on the directive from SJR 32 that the study examine "measures adopted by other states to address the liability insurance problems related to liability insurance for health care facilities and health care providers associated with health care facilities".

The information that follows is presented in two parts: (1) Montana's medical liability law and reforms; and (2) policy alternatives. The first category of information summarizes current Montana law and practice. The second category of information summarizes some of the legal alternatives for addressing or resolving medical liability issues.

The objectives of the remainder of this chapter are twofold. First, because SJR 32 directs the Subcommittee to assess factors affecting the cost of liability insurance and because there are both perceptions and assertions that the status of a state's tort law may be or is a driver of insurance premiums in that state, the first part of the report attempts to articulate or clarify the status of tort law and tort reform in Montana, both

⁵⁶ The NCSL effort and the AMA collection are each included herein, respectively, at Appendix B and Appendix C.

individually and with respect to other states.

Second, because SJR 32 also directs the Subcommittee to examine measures adopted by other states to address liability insurance problems, strategies for increasing availability of affordable liability coverage, and strategies for resolving liability claims outside of the court system, the second category of information summarizes some alternatives adopted by or under consideration in some other states. Additionally, alternatives identified by individuals, academics, associations, et al., are also discussed in furtherance of the SJR 32 objectives.

PART 1: Montana Medical Liability Law and Reforms

Montana fairs very well in the category of enactment of "tort reform" measures, especially when compared with the states on the American Medical Association list of states that are "OK" in terms of the cost and availability of medical liability insurance, including a comparison with California, the claimed "Gold Standard" of tort reform. Montana fairs well both in terms of the type of legislation and the quality of legislation...

Year 2003 Montana Medical Legal Panel Report

Montana's law regarding medical liability was in a state of transition from about the late-1980s through the mid-1990s. In part, long standing practices and traditions were actual or perceived impediments to the welfare of Montana citizens, medical providers, and medical facilities. Then, in 1995, during the 54th Legislative Session, the state's medical liability statutes were substantially revised to reflect policies adopted in

other states, particularly California.⁵⁷ Since then, Montana's Legislatures have mostly left medical liability statutes alone-- except, perhaps, when legislators perceived that the Supreme Court had subverted legislative policy.

In short, Montana's medical liability statutes currently reflect policies that are strongly advocated by medical practitioners, medical facilities, and medical liability insurers. Compared to other states, Montana's statutes now rank among the elite. Montana statutes reflect a philosophy that:

- an injured party should be fully compensated -- no more, no less -- for all actual damages and sufficiently compensated for noneconomic damages;
- responsibility for damages should be determined and assessed on a proportional basis among those responsible for the injury;
- medical practitioners, medical facilities, and insurers should have some confidence in the predictability of liability insurance premiums and availability at a reasonable cost; and
- public policy should not result in adverse consequences for citizens, medical practitioners or facilities, or insurers and should, wherever possible, act as a catalyst to reduce unpredictability, stabilize or reduce liability insurance rates, increase the availability of insurance, enhance the image of Montana as a great place to practice or provide medical services.

Statute of Limitations: 27-2-205, MCA

Montana law requires a plaintiff in a medical malpractice action to commence the action within 3 years after the date of injury or within 3 years after the plaintiff discovers or through the use of reasonable diligence should have discovered the injury, whichever occurs last, but in no case may an action be commenced after 5 years from the date of

⁵⁷ See House Bill No. 309, Ch. 461, Laws of Montana 1995.

injury.⁵⁸ However, for death or injury of a minor who was under the age of 4 on the date of the minor's injury or death, the period of limitations begins to run when the minor reaches the minor's eighth birthday or dies, whichever occurs first.

Underlying arguments for a statute of limitation, such as is in 27-2-205, MCA, include providing some assurance of a cause and effect relationship between the alleged act or omission and the injury claimed, as well as providing some predictability for practitioners, facilities, and insurers.

Underlying arguments against both a statute of limitations or a relatively brief statute of limitations include situations in which the injury or its effects don't manifest until a significant period of time elapses, during which the injured party is unaware that the injury has occurred.

Limits on Noneconomic Damages: 25-9-411, MCA

In a malpractice claim or claims against one or more health care providers based on a single incident of malpractice, Montana law, since 1995, has limited an award for past and future damages for noneconomic loss to a maximum of \$250,000.⁵⁹ All claims for noneconomic loss deriving from injuries to a patient are subject to an award not to exceed \$250,000. If more than one patient claims malpractice for separate injuries, each plaintiff is limited to \$250,000 in noneconomic damages.

Underlying justification for limiting noneconomic damages relies heavily on the fact that all *economic* damages -- past, current, and future medical bills, loss of future earnings, etc. -- are completely covered, that

⁵⁸ This time limitation is tolled for any period during which there has been a failure to disclose any act.

⁵⁹ The \$250,000 limit is the same as California's limit est. in 1975 and is the amount advocated by reform advocates at the national level. See President Bush's MMLI policy summarized on the Internet at URL <http://www.whitehouse.gov/news/releases/2003/01/20030116.html> and "AMA Chief Touts Tort Reform as Cure for Malpractice Woes" by Kevin Kemper in *BizJournals* online May 31, 2004, at URL <http://www.bizjournals.com/columbus/stories/2004/05/31/focus5.html>.

noneconomic damages are difficult to value in economic terms, and that noneconomic damage awards can vary widely for similar injuries or that such awards can vary widely among different jurisdictions and even within the same jurisdiction.

Underlying arguments against limiting noneconomic damages include a recognition that the economic damages awarded to an injured party, although fully covered, may not reasonably value the worth of certain types of work, e.g., a home maker, or cannot reasonably value the future lost wages of a child. Thus, economic damages can vary substantially for virtually identical injuries suffered by different individuals without the possibility of a corresponding variation in noneconomic damages that would, in essence, result in equal treatment among individuals in similar circumstances. Additionally, there are certain injuries, e.g., loss of sight, movement, or sexual function, and circumstances, e.g., extraordinary pain, suffering, etc., for which an arbitrary limit or cap may not seem to adequately compensate for the injury.

Collateral Source Rule: 27-1-308, MCA

In Montana, the law states that in a case in which the damages exceed \$50,000, the total damages must be reduced by the amount of prior payment from collateral sources that do not involve rights of subrogation. The judge -- rather than the jury -- applies the rule and is by the statute to effect the offsets.

The underlying argument for the collateral source rule is to preclude a claimant from receiving payment more than once for the same injury.

Against the rule the argument is that reducing an award by amounts contributed from collateral sources rewards those who are culpable or responsible for the injury or damages at the expense of the injured party.

Joint and Several Liability: 27-1-703, et seq., MCA

In Montana, if the negligence of a party to an action is an issue, each party against whom recovery may be allowed is, with exceptions, jointly and severally liable for the amount that may be awarded to the claimant. However, each party that is negligent has the right of contribution from any other party whose negligence may have contributed as a proximate cause to the injury. An exception to the general rule occurs whenever a party whose negligence is determined to be 50% or less of the combined negligence of all parties determined to be negligent is severally liable only and is responsible only for the maximum percentage of negligence attributable to that party. Another exception is that a party may be jointly liable for all damages caused by the negligence of another party if both acted in concert in contributing to the claimant's damages or if one party acted as an agent of the other.

The advisability for reforming the joint liability doctrine, which Montana did in 1995 and 1997, is predicated on the belief that determining liability should be a system of comparative fault in which persons are held responsible only to the extent to which they cause or contribute to the harm. Further, advocates argue that joint liability reform should apportion liability among all tortfeasors according to their equitable share of fault, rather than only among parties to the action. It is argued that without the reform solvent defendants have to pay for the liability of insolvent, immune, or settled parties. In short, the reform limits the exposure of a defendant with a "deep pocket".

In contrast, arguments against reforming the doctrine include limiting the ability of an injured party and making it more difficult for the injured party to fully recover due compensation for the injury incurred.

Periodic Payments: 25-9-412, MCA

A party to an action for a medical malpractice claim in which \$50,000 or more of future damages is awarded may request the court to enter a judgment ordering future damages to be paid in whole or in part by periodic payments rather than by a lump-sum payment. If such a request is made, the court must enter an order for periodic payment of future damages. The total dollar amount of the ordered periodic payments must equal the total dollar amount of the future damages without a reduction to present value. If the injured party dies prior to full payment of the award, the remainder of the award becomes part of the decedent's estate.

The arguments favoring periodic payments include the premise that guaranteed periodic payments, such as through an annuity, will assure that the injured party will have resources available for the duration of the injury or the life of the injured party. This approach provides some assurance that the injured party will not become a burden to the public fisc. A periodic payment schedule also allows the party responsible for making payment to better plan and accommodate the payments, compared to a one-time or lump sum payment.

First, in opposition to periodic payments, it is sometimes the case that the injured party may not survive to benefit fully from the award. In such cases, it is argued, the injured party is not only subjected to the injury that is the cause of action, but also to subsequent financial injury. Additionally, there is the argument that once the award is made the injured party should be given the full amount immediately as the award is considered to be full compensation *at the time the award is made* without having to adjust for or "crystal ball" the vagaries of future events, e.g., inflation.

Pretrial Screening: Title 27, chapter 6, MCA

Montana has a forum, the Montana Medical Legal Panel⁶⁰, and *mandatory* process established to prevent where possible the filing in court of actions against health care providers and their employees for professional liability in situations where the facts do not permit at least a reasonable inference of malpractice. In cases where malpractice is reasonably suspected, the Montana Medical Legal Panel makes possible the fair and equitable disposition of claims against health care providers without the complexities, expense, and time-investment of the legal process.

The principal argument for pretrial screening is the same as the purpose of the Montana Medical Legal Panel; i.e., it gives both the injured and accused parties the opportunity to have an objective "outsider" consider and comment on the claim prior to investing time, effort, and money in a legal process that might be avoidable. For example, if the Panel determines that the claim is wholly without merit, the claimant may drop the issue without any further action. Alternatively, if the Panel believes that the claim is meritorious, the defendant may reconsider negotiating and settling the claim outside the legal processes.

Arguments against the process include the additional time and, potentially, money that it takes to have a claim adjudicated in court -- time and money that plaintiffs frequently do not have. Additionally, there is the possibility that the claimant or the defendant, or both, might (mis)use the process only to preview or discover the strength of the evidence and arguments of the adversaries or the perceptions or conclusions reached by an objective deliberative body.

⁶⁰ There is also the Montana Chiropractic Legal Panel that screens claims of chiropractic malpractice. The forum and processes essentially parallel those of the Montana Medical Legal Panel. See Title 26, ch. 12, MCA.

Expert Witness Rules: Title 26, chapter 10, part VII, Rule 702, MCA

The Montana Legislature has not enacted a statute defining the qualifications of an "expert witness" in medical malpractice cases. Rather, the Supreme Court has ordered, by Rule, that,

... if scientific, technical, or other specialized knowledge will assist the trier of fact to understand the evidence or to determine a fact in issue, a witness qualified as an expert by knowledge, skill, experience, training, or education may testify thereto in the form of an opinion or otherwise.⁶¹

This rule is identical to Federal and Uniform Rules (1974) Rule 702. Montana's Rule states the two common-law standards required before an expert is allowed to give his or her opinion, each of which standards is found in existing Montana law.⁶²

Further, a party may require through interrogatories any other party to identify each person whom the other party expects to call as an expert witness at trial, to state the subject matter on which the expert is expected to testify, and to state the substance of the facts and opinions to which the expert is expected to testify and a summary of the grounds for each opinion. (See, Title 25, ch. 20, pt. V, Rule 26(b), MCA.)

⁶¹ Ad. Sup. Ct. Ord. 12729, Dec. 29, 1976, eff. July 1, 1977. The Montana Supreme Court adopts, revises, repeals, etc., the Rules of Civil Procedure. Those Rules are published in the MCA *only* as a matter of convenience and courtesy to the Judiciary and the Bar. Because the Rules are within the purview of the Judiciary--much like the Rules of the Legislature are within the purview of the Legislature--the Legislature has been dissuaded from attempting to revise or repeal the Supreme Court's Rules.

⁶² See "Commission Comments" in Title 26, ch. 10, pt. VII, 702, MCA.

According to the NCSL, 31 of the 50 states have statutes that address "expert witness" designation. The various states' statutes range from fairly weak or vague⁶³ to fairly strong or definitive.⁶⁴

Arguments in favor of establishing qualifications of "experts" *a priori* include precluding claimants or their attorneys from filing frivolous claims or, at least, mitigating the frequency and severity of the filing of frivolous claims.⁶⁵

Arguments against specifying expert qualifications include the additional time and expense to the claimant involved in finding/hiring the expert, which some individuals perceive as barriers to due process of law.

Attorney Fees

Attorney fees or, rather, limiting attorney fees, is another entry on the checklist of liability laws or reforms.

For a few of the most adversarial cases, a claimant may feel compelled to retain legal counsel or, ultimately, to file a lawsuit. Reportedly, many or most of these cases are taken by legal counsel on a "contingency fee" basis, in which the attorney is compensated only if the claimant/plaintiff receives an award. The amount of the contingent fee varies, but is typically at least 30% of the award depending on the complexity of the case and the level of the legal system at which the case is ultimately resolved.

⁶³ Under Illinois code (735.5-8), the plaintiff is required to provide an affidavit stating that a competent expert has been consulted. (*State Medical Liability Laws Table*, NCSL, 2003.)

⁶⁴ For example, the Michigan code requires that an "expert" must be a licensed health professional, practice in a similar specialty, be board certified (if required on the specialty) during the year preceding the action, and had clinical or academic experience in the specialty. A certificate of consultation must be filed with claim. (*State Medical Liability Laws Table*, NCSL.)

⁶⁵ However, without requiring extremely stringent qualifications, it is very unlikely that what may be perceived by the accused practitioners or facilities to be "frivolous" claims will not be pursued by the claimant. More likely, there will always be an expert to be found who will attest to the merits of the claim. (Conversation with Larry Riley, Esq., Montana Defense Trial Lawyers Association, September 2003.)

With respect to medical malpractice claims, Montana has not enacted limits on attorney fees⁶⁶, whereas some other states have.

Arguments in favor of limiting legal fees include the fact that a sizeable portion of the compensation awarded to the injured party is paid to the claimant's attorney. Additionally, some interests contend that fewer claims would be filed or pursued if trial attorneys did not have the opportunity to recover (potentially) large sums as contingency fees.

Against placing limits on legal fees are arguments that injured, low-income individuals would be shut out of the legal process if not for attorneys who are willing to gamble their own time and resources on the possibility that an award or settlement will be won. Further, those opposed to limits counter that the amounts received for some, perhaps many cases taken on contingency are insufficient to cover the cost incurred by the attorney for that case. Finally, opponents point to the significant legal resources available to medical providers and facilities: ample legal counsel (both quantity and quality); considerable financial resources for, e.g., discovery, expert witnesses, etc.; and the luxury of time, a commodity that many injured claimants have little of.

Contributory or Comparative Negligence or Fault: 27-1-702, MCA

The concept of contributory or comparative negligence or fault is closely associated with joint and several liability. Contributory negligence does not bar recovery in an action to recover damages for negligence resulting in death or injury if the contributory negligence was not greater than the negligence of the person or the combined negligence of all persons against whom recovery is sought, but any damages allowed must be diminished in the proportion to the percentage of negligence attributable to the person recovering.

⁶⁶ In Montana, attorney fees in Workers' Compensation cases are limited under 39-71-613, MCA.

The arguments pro or con are essentially the same as the arguments for or against joint and several liability. Essentially, by advocates, that liability should be borne in proportion to fault or, by opponents, that the injured party is potentially subjected to additional time and expense in order to gain compensation for the injury.

Vicarious Liability or Ostensible Agency: 28-10-103, MCA

The premise of vicarious liability or ostensible agency is that a person who causes, directly or indirectly, a second person to believe that a third person is employed by or is an agent of the first person is liable for damages caused to the second person by the third person even though the third person is not employed, *per se*, by the first person. The underlying premise of ostensible agency is also related to the concept of joint and several liability yet, on the surface, could seem to contradict the tenets of comparative fault.

Montana has recognized ostensible agency since the state's early days, having enacted the original statute in 1895 and leaving it unchanged since enactment.

As a factor in medical liability insurance, the Montana Supreme Court, in *Butler v. Domin* (2000 MT 312, 302 M 452, 15 P3d 1189, 57 St. Rep. 1320 (2000)) concluded that,

... a hospital will be deemed to have held itself out as a provider of care unless it gives notice to the patient that it is not the provider of care and that the care is provided by a physician who is an independent contractor and not subject to the control and supervision of the hospital.

With respect to ostensible agency, proponents view the application of

the tenet as a legitimate means to ensuring that an injured person could be fully compensated for an injury incurred.

In contrast, opponents see little, if any, relationship between the person who actually causes the injury and a virtually uninvolved party who has merely contracted for the services of the party that caused the injury.

Prejudgment Interest: 27-1-210, MCA

In Montana, it has been a matter of statutory law for nearly 20 years and a judicial practice prior to enactment of the 1985 law that interest may be awarded "on any claim for damages awarded that are capable of being made certain by calculation", i.e., actual damages but *not* noneconomic damages or court costs or attorney fees.

Arguments associated with prejudgment interest revolve around the concept of the time-value of money and the pecuniary effects of inflation.

Summary of Montana Medical Liability Laws and Tort Reforms

From time to time, Montana has been seen as a state in which liability was so liberally construed as to compromise the welfare of, in this instance, medical practitioners and facilities. And, similar to citizens in many other states, Montanans have witnessed the enactment, application, and revision of various legal elements that affect or are affected by the theoretical and practical implications of medical liability.

For good, ill, or naught, past Montana Legislatures have responded to the previously reported "crises" in medical liability and general liability through adopting legislation that articulates public policy with respect to assignment of liability, protection from liability, just compensation, proportionate accountability/responsibility, and economic reality. Over the past 20 years or more, Montana's Legislatures have gradually enacted or

revised the state's laws to mitigate what have reportedly been the most egregious legal liability pitfalls, gravitating to the point where Montana is now recognized, by some at least, to be as "medical-liability-insurance friendly" as nearly any other state.⁶⁷

PART 2: Policy Alternatives

The final paragraph of Part 1 of this chapter could be interpreted to mean that whatever forces are driving the increasing prices of and decreasing availability⁶⁸ of medical liability insurance, Montana's tort law is probably *not* one of the factors. In fact, if the tort law policies advocated by, e.g., the American Medical Association, et al., truly have the results that the AMA predicts they should have, Montana's tort law should be acting to mitigate price increases and enhance the availability of medical liability insurance. Adoption of SJR 32 and testimony to the Subcommittee are evidence to the contrary.

Thus, the Subcommittee looked at other alternatives to identify different changes in public policy to further promote liability insurance price reduction and availability or at least stability in both price and availability.

Certificate of Merit

⁶⁷ See, e.g., Gerald J. Neely, G. Brian Zins, and Kathy Whitehead, *Year 2003 Montana Medical Legal Panel Report, Executive Summary*, March 17, 2003; *Medical Malpractice: Implications of Rising Premiums on Access to Health Care*, U.S. General Accounting Office, August 2003, p. 17-21. (GAO-03-836); *Medical Malpractice Insurance: Multiple Factors Have Contributed to Increases Rates*, U.S. General Accounting Office, June 2003, pp. 22, 45,. (GAO-03-702).

⁶⁸ Information provided by the Montana Insurance Commissioner shows that the number of insurers offering medical liability insurance has remained quite steady over the past several years, with some insurers exiting the market and others entering.

A certificate of merit requirement would require a plaintiff to obtain an expert assessment of the claim at the outset of the suit. As characterized by Catherine T. Struve.⁶⁹,

Some 17 states currently impose certificate of merit requirements in medical malpractice actions. The goal in each state appears similar: to deter plaintiffs from filing meritless claims. Each state's certificate of merit provision requires the plaintiff to provide a certification that the case has been reviewed by an expert and that the expert has concluded there is some basis for the claim. Beyond this essential similarity, however, the provisions vary significantly. (Struve, p. 48)

The applicability of the certificate plus the person who must certify and certificate content can and do vary from state to state. For example:

- does the plaintiff's "expert" certify that the claim is meritorious or does the plaintiff's attorney certify that an expert has reviewed the claim for merit?
- at what level of specificity is the standard of care required to be stated?
- at what level of specificity must the breach of the standard of care be stated?
- at what level of specificity must the breach of the standard of care be identifiable as the cause of the injury and be stated?
- is there simply a requirement that the expert certify that the claim is not meritless or unjustifiable?

⁶⁹ *Expertise in Medical Malpractice Litigation: Special Courts, Screening Panels, and Other Options*, by Catherine T. Struve, for The Project on Medical Liability In Pennsylvania, Pew Charitable Trust, pub, Columbia University, c. 2003. The certificate of merit requirements applicable to medical malpractice actions exist in Colorado, Connecticut, Florida, Georgia, Illinois, Maryland, Michigan, Minnesota, Missouri, Nevada, New Jersey, New York, North Carolina, North Dakota, Pennsylvania, Texas, and West Virginia. (Struve, p. 48.)

In her research, Struve found that the empirical evidence regarding the efficacy of certificate of merit requirements is scarce and that what evidence there is does not seem to support the "deterrence theory".⁷⁰

Relying on Struve's research, the Subcommittee was advised that any certificate of merit requirement should have components that are (1) based on the goal of the provision and (2) the potential adverse effects. Stipulating that some form of "screening out weak malpractice claims" is the goal of a certificate of merit, the legal requirement should require the plaintiff's attorney to attest that he or she has consulted an "expert" and the expert has reasonably determined that the defendant *negligently* caused the plaintiff's injury.⁷¹

Among the potential adverse effects described for the Subcommittee is the availability of and access to information about the injury. While medical records may be available, the defendant and others may not be available for interviews. Further, legal restrictions to accessing medical records may preclude the timely review of relevant records.⁷²

Another adverse effect identified is the cost of obtaining a certificate. The expert will likely not render a professional opinion for free and even the plaintiff's attorney may require the plaintiff to pay for the expert "up front". Sometimes, one expert may be hired to obtain the certificate and another expert retained for trial, thus potentially doubling the expense.⁷³ Further, the Subcommittee was cautioned that requiring a certificate of merit as a prerequisite may violate a plaintiff's constitutional right of equal

⁷⁰ Ibid., p. 50.

⁷¹ Ibid., p. 51.

⁷² Ibid, pp. 51-52.

⁷³ Ibid., p. 52.

access to the courts⁷⁴, right to trial by jury⁷⁵, or right to equal protection.⁷⁶

Although the Subcommittee was asked to recommend "certificate of merit" legislation and discussed the option at length, they do not recommend establishing a certificate of merit.

Screening Panels

Montana's medical legal panels were addressed previously in this report but fall within this category of "alternatives" nevertheless. The Subcommittee considered that Montana's current process could be revised to, for example, alter the composition of the panels, reduce or expand the time allowed for panel review or decision, revise the amount of discovery or types of evidence allowed, scope of findings, or (possibly) allow or require the findings, conclusions, and decision of the panel to be admissible at trial. The Subcommittee was also alerted that the efficacy of such panels, in general, is questionable and the limited research suggests "that panels have not brought much overall improvement in malpractice litigation"⁷⁷ -- *the experience of the Montana Medical Legal Panel notwithstanding*.⁷⁸

⁷⁴ See, e.g., *Aldana v. Holub*, 381 So.2d 231 (Fla. 1980); and *Cardinal Glennon Mem. Hosp. v. Gaertner*, 583 S.W.2d 107 (Mo. 1979). (Cited in Struve, p. 57, footnotes 1 and 3.)

⁷⁵ See, e.g., *Mattos v. Thompson*, 421 A.2d 190 (Pa. 1980). (Cited in Struve, p. 57, footnote 4.)

⁷⁶ See, e.g., *Hoem v. State*, 756 P.2d 780 (Wy. 1988). (Cited in Struve, p. 57, footnote 6.)

⁷⁷ *Expertise in Medical Malpractice Litigation: Special Courts, Screening Panels, and Other Options*, by Catherine T. Struve, for The Project on Medical Liability In Pennsylvania, Pew Charitable Trust, pub, Columbia University, c. 2003, p. 56.

⁷⁸ Quote: "The Panel has concluded that "Montana's Medical Legal Panel - which "screens" medical liability claims as a pre-condition to any lawsuit - has produced and is directly responsible for one of the lowest, if not the lowest, rates of medical liability court cases in the United States. This is readily-observable from the rate of lawsuits prior to the existence of the Voluntary Screening Panel that pre-dated the current Mandatory Panel, during the later period of no panel and during the period of the current Mandatory Panel, when contrasted with national and state studies of rates of lawsuits." (Gerald J. Neely, G. Brian Zins, and Kathy Whitehead, *Year 2003 Montana Medical Legal Panel Report, Executive Summary*, March 17, 2003, p.2.)

The Subcommittee was advised that study on the effects that panels may have on the frequency and severity of claims is inconclusive, possibly because of the lack of empirical research. What little can be inferred from the research suggests that panels have little effect on either the frequency of claims or severity of claims paid.⁷⁹

In addition to the remaining questions regarding frequency and severity of claims, conclusions about the effects that panel have on insurance premiums are mixed. One longer-term (13 years) study found "no statistically significant effect on premiums for general practitioners or general surgeons (though it did find that panels were associated with a statistically significant reduction in premiums for obstetrician-gynecologists).⁸⁰

Possible adverse effects of panels or of changes to Montana's existing panel were listed for the Subcommittee and included additional time/expense involved for final resolution, more expense involved in discovery, scheduling difficulties, and even "trying the case twice".

Ultimately, the Subcommittee determined that the legal panels have accomplished the intended policy objectives and, consequently, does not recommend changes.

Specialized "Medical Malpractice" Courts

The underlying premise for advocates of medical malpractice courts is that increasing the specialization and expertise among judges would be beneficial to all involved: plaintiffs, defendant-practitioners, and insurers. More judicial expertise in medical issues, it is argued, could enhance the

⁷⁹ *Expertise in Medical Malpractice Litigation: Special Courts, Screening Panels, and Other Options*, by Catherine T. Struve, for The Project on Medical Liability In Pennsylvania, Pew Charitable Trust, pub, Columbia University, c. 2003, pp. 60-64.

⁸⁰ Primary source of conclusion found in Zuckerman, Stephen, Randall R. Bovbjerg, and Frank Sloan. 1990. Effects of Tort Reforms and Other Factors on Medical Malpractice Insurance Premiums. *Inquiry* 27(2):167-82. Cited in Struve, p. 65.

speed and the consistency and coherence of outcomes. Additionally, expert judges might be better able to assess the qualification of "expert" witnesses or the "reasonableness" of awards for both actual and noneconomic damages, as well as provide other procedural and substantive benefits.

A corollary premise is that an expert judge can better determine the "standard of care" threshold than can a jury, that the standard of care is more a matter of law (within the judge's purview) than it is a matter of fact (with the jury's purview), and that, as a matter of law, judges' decisions in medical malpractice cases could set precedents for guiding physicians' subsequent conduct.

The Subcommittee was also alerted to adverse implications of specialized courts, including the cost to establish a separate judicial system within the existing system, the simple fact that there may be and typically are more than one legitimate approach to diagnosis or treatment that would or could be viewed to meet the "standard of care", and that the precedential value of judges' decisions is questionable due to the rapid pace of change in medical knowledge, understanding, technology, therapies, etc.

The Subcommittee was warned that there is a risk of "politicizing" the medical malpractice bench. Struve notes that "[C]ommentators have long pointed out that the more specialized a court is, the greater the incentives and opportunities for interest groups to seek to influence the court's decisions, both by lobbying to select judges who will favor the desired position and by exerting pressure on the court in connection with particular cases."⁸¹ The risk of politicization is exacerbated if judges are elected.

⁸¹ *Expertise in Medical Malpractice Litigation: Special Courts, Screening Panels, and Other Options*, by Catherine T. Struve, for The Project on Medical Liability In Pennsylvania, Pew Charitable Trust, pub, Columbia University, c. 2003, p. 73.

A specialized court would, over time, narrow the perspectives of its judges by focusing their attention in only one area rather than expanding their vision among various areas. With narrower focus, specialized judges could become unaware of parallels to be drawn from other areas and potentially diverging from the larger body of law.⁸²

The cost implications accrue not only to the public fisc, but also to the plaintiffs -- it is highly unlikely that the number of medical malpractice courts would equal the number of district courts or that a specialized court would be located as close to plaintiffs as district courts do currently. Additionally, fewer and more distant trial venues would increase costs for juries, including selection, expense reimbursement, etc.

To counter some of the potential disadvantages of a specialized court discussed above, Struve offers some provocative suggestions.

If trial judges lack skill in assessing the admissibility of expert testimony, judicial training sessions could improve their understanding of the scientific method, probabilistic evidence, and other relevant topics. If specialized judges remain desirable, a separate court is not the only way to provide them. A specialized medical malpractice division could be created within a particular county's Court of Common Pleas, and judges could rotate into and out of that division. This option could reduce the politicization and perspective-narrowing problems identified above, while providing an opportunity for judges to gain concentrated experience in malpractice litigation. A specialized division, moreover, would not force litigants to travel large distances in order to pursue medical liability claims.... Those concerned principally with variations in jury awards, rather than judicial competence, might consider other reforms that tackle the jury issue directly, such as benchmarks to guide damage calculations.⁸³

⁸² See, e.g., *Ibid.*, pp. 75-76, for a more complete discussion.

⁸³ See, e.g., *Ibid.*, pp. 80-81.

Expert Witnesses

Recognizing that the issue of expert witnesses in the context of Montana law was touched upon previously, tort reform advocates point to unqualified "experts" being allowed to testify as one factor that leads to undesirable outcomes, not only disproportionate awards but even unjustified or unproved verdicts finding malpractice where none existed. There are at least two options available to address this concern: (1) expert qualifications that are higher, stricter, more definitive, etc., than may currently be present; or (2) allowing the judge, rather than the plaintiff and defendant, to select a "neutral" expert.

On their face, either option could be seen as a credible, objective move toward "finding the Truth" and away from the traditional approach of simply pitting one expert against another. Furthermore, each option has suboptions to consider, e.g., a court appointed "expert" to determine or evaluate the qualifications of (especially) the plaintiff's expert, or a court appointed expert to sift through the complexities of the case or contradictory findings or testimony of other experts and objectively synthesize the expert testimony for the jury.

In a mini-reprise of the testimony on HB 695 (2003), the Subcommittee was encouraged to recommend a statute prescribing qualifications for experts in medical liability actions. The advocates' arguments prevailed in that the Subcommittee recommends LC 5008, establishing criteria that an "expert" must meet in medical malpractice litigation.

*Jury Education*⁸⁴

Rather than treat jury members as passive actors waiting to be persuaded by various experts, the Subcommittee was told that the court could act to inform juries of the rules of evidence prior to the trial actually

⁸⁴ See, e.g., *Ibid.* pp. 87-90.

beginning. There is also the possibility of providing instructions to the jury before, as well as after, testimony is given. Periodic summaries of evidence, key exhibits, etc., by the attorneys or the judge could also help jurors to separate the wheat from the chaff.

A possible downside of jury education is that additional time and expense would be a near certainty.

Variability of Jury Awards

To the extent that variability of jury awards is inherently undesirable or bad, providing legislative guidance in structuring how damages, particularly noneconomic damages, are assessed is arguably an option.⁸⁵ Struve again identifies variations on the theme that could include:

- lawyers could be permitted to frame their arguments concerning damages around prior awards in cases they consider comparable;
- juries could be given one or more stylized scenarios and associated valuations to use as benchmarks in considering how much to award;
- awards could be set by means of "a matrix of values" that would award fixed damage amounts according to the severity of injury and age of the injured party,"
- awards could be constrained by "a system of flexible floors and ceilings" that vary with injury severity and victim age";
- instead of arguing damages to the jury (which would only determine factual matters, e.g., malpractice), lawyers could be required to make a similar case to the judge (who would establish damages as a matter of law, not fact);
- require that any award that deviates materially from reasonable compensation will result in *remittitur* if the jury award is excessive.⁸⁶

⁸⁵ This option is "arguable" due to the right to "full legal redress" provided under Art. II, sec. 16, Montana Constitution.

⁸⁶ *Expertise in Medical Malpractice Litigation: Special Courts, Screening Panels, and Other Options*, by Catherine T. Struve, for The Project on Medical Liability In Pennsylvania, Pew Charitable Trust, pub, Columbia University, c. 2003, p. 88. (By implication, this options suggests that an inadequate award will result in *additur*.)

According to David Sclar and Michael Housman writing in the *Harvard Health Policy Review* point to emerging reform proposals that:

... would significantly alter the process for resolving claims, as well as physicians' relationship to malpractice liability, in some cases removing the physicians from the process entirely. These new reform proposals fall under four categories: alternative dispute resolution, enterprise liability, selective no-fault malpractice compensation and clinical practice guidelines as the standard of care.⁸⁷

Alternative Dispute Resolution

Alternative Dispute Resolution or ADR is an increasingly common approach to determining facts, assigning responsibility, assessing damages, or a combination. To date, ADR is not used extensively in medical malpractice cases, but is becoming increasingly present in general liability. Relying again on the observations of Sclar and Housman:

Alternative Dispute Resolution (ADR) can come in many different forms that ultimately remove disputes from the judicial system and place them in the hands of one or more professional arbitrators, thus eliminating the jury. Some forms of ADR include arbitration, mediation, neutral evaluation and summary jury trials. In the case of arbitration, the decision can be non-binding in that a party can continue to pursue the claim within the legal system if he is not pleased with the result, or, on the other hand, the decision may be the arbitrator's, in which case the option of court appeal is limited. The decision to submit the case to binding or non-binding arbitration is voluntary, and must be made before the case has been heard. In the past, arbitration has been infrequently used to resolve malpractice claims, but extensively used in commercial settings, and

⁸⁷ *Harvard Health Policy Review*, "Medical Malpractice and Physician Liability: Examining Alternatives to Defensive Medicine", by David Sclar and Michael Housman, Spring 2003, Vol. 4, No. 1; Internet URL: <http://hcs.harvard.edu/~epihc/currentissue/sclar-housman-e.php>.

it has been demonstrated to be less costly in resolving disputes.⁸⁸

Enterprise Liability

A common practice in general corporate law, "enterprise liability", is a relationship in which the corporation assumes liability rather than the employee. Under this system as it would apply to medical liability, a hospital, clinic, or other enterprise would assume liability for any alleged malpractice committed by a physician who works in the hospital, clinic, etc.⁸⁹ There are clear advantages to this approach according to Sclar and Housman:

The major advantage that enterprise liability poses over the medical malpractice trial system, as it is currently structured, is that it relieves the physician of personal liability.... Furthermore, it compels the healthcare institution to more closely monitor the care that is given to its enrollees, and to take responsibility for quality improvement.⁹⁰

Potential drawbacks to enterprise liability include the changes in the relationship between the physician and the facility. Almost certainly those changes would result in a reduced level of autonomy for the practitioner, both in the way that he or she prefers to practice medicine and in the manner in which he or she behaves as an employee rather than as a privileged physician.

One thing that would not change would be that a physician accused of malpractice would continue to have his or her diagnoses, actions, and

⁸⁸ Ibid. p. 2 on Internet version.

⁸⁹ It is unclear in reading Sclar and Houseman whether or not enterprise liability coverage extends to everyone who works in the enterprise or only for those who work for the enterprise. This is an important distinction because most hospitals grant "privileges" to physicians to treat patients in the hospital, but many or most privileged physicians also have private practices of their own, as part of a group practice, a limited liability partnership, etc. Consequently, privileged physicians are not "employees" of the enterprise as is the case in the context of enterprise liability as it applies in the general corporate world.

⁹⁰ Ibid, *Sclar and Housman*, p. 2 on Internet version.

professional judgment subjected to scrutiny and criticism, even though he or she would avoid any liability if malpractice were found to have occurred.

Selective No-fault Liability

The concept of selective no-fault liability proffered for medical liability is not unlike the decades-old "workers' compensation" system. In practical terms, a no-fault system would replace the fault-based tort liability system with a list of adverse outcomes from medical care for which claimants/victims would be compensated for economic loss, regardless of the acts or omissions of a medical practitioner or facility. The list would be limited to "avoidable classes of events" or ACEs and to each ACE would be attached a mechanism for determining compensation. Victims of ACEs would be automatically compensated merely as a result of the injury and without any finding of fault.

Selective no-fault liability is limited in practical application, however, because it would be impossible to identify, catalog, evaluate, and appraise the economic value of every conceivable ACE in every conceivable set of circumstances.

Florida has adapted a very specific version of "no-fault" with its NICA program (Neurological Injury Compensation Association). Created in 1988 at the height of Florida's last malpractice insurance crisis, the NICA program is designed to stabilize the insurance market against catastrophic birth-related injury claims, ensure that most of the payments go to patients instead of lawyers, both plaintiff and defense, and provide reasonable benefits to the injured child's parents. Under fairly rigid criteria, outside medical experts scrutinize a potentially eligible child's medical records prior to determining a NICA award or benefit.

The *Palm Beach Post* reported⁹¹ that fewer than 175 children have been covered by NICA since 1988. The report also cited a study conducted by faculty at Duke University and Vanderbilt University that concluded that under NICA, "beneficiaries broke even" while families that received awards through tort settlements were "overcompensated". Notably, NICA does not account for a child's lost income, typically seen as an actual damage. In contrast, tort settlements and verdicts typically do indemnify for a child's lost income.

Clinical Practice Guidelines

One of the more forceful propositions, clinical practice guidelines or CPGs, take the concept of "standard of care" to a somewhat higher level in which the standard is specifically laid out in a volume of guidelines. If adopted, typically through legislation, CPGs would immunize physicians from suit provided that the applicable CPGs were followed, even where the clinical outcome was adverse to the patient. Sclar and Housman are clear in their description of perceived advantages of CPGs.

... clinical practice guidelines actually provide physicians with guidance on which medical practices are beneficial to the patient and which are either wasteful or potentially harmful. In this respect, CPGs have the potential to end clinical practices that began for defensive reasons and have long since become ingrained in the physician's mentality as the standard of care. Furthermore, court admission of the clinical practice guidelines ensures that clinical standards are the basis for determining cases. They may therefore eliminate the need to solicit testimony from expert witnesses who can carry widely divergent opinions regarding appropriate medical practice...⁹²

⁹¹ "Malpractice alternative pays less", *PalmBeachPost.com*, June 15, 2003, Internet URL http://www.palmbeachpost.com/business/content/business/insurance_myths_061503.html

⁹² Ibid. *Sclar and Housman*, p. 3 on Internet version.

Among the potential disadvantages of CPGs, Sclar and Housman are just as clear.

Drafting and applying clinical practice guidelines are not yet perfect processes, and face a number of challenges. Clinical guidelines must leave room for physician discretion since real-life clinical scenarios are rarely black and white. The uncertainty in medicine makes CPGs difficult to create for certain treatments and procedures in which the standard of care is unclear. Furthermore, it becomes difficult to create clinical guidelines for every procedure imaginable, so there will certainly be some malpractice trials for which clinical guidelines are unavailable and proceedings revert to reliance on expert testimony and subjective judgments about malpractice. Consequently, the use of clinical guidelines may be limited, and may therefore only have an impact on certain cases of malpractice litigation.⁹³

Insurance Market Interventions

Insurance market interventions are identified by the National Governor's Association as "stopgap solutions that address the lack of affordable or available insurance, such as providing subsidies to providers or creating state-run insurance programs. These measures typically are thought of as short-term or providing an option of last resort and may not solve the systemic issues that insurers and providers believe exist in the medical liability insurance market."⁹⁴ The following descriptions, as compiled and summarized by the National Governor's Association, outline several insurance market interventions.

- State-Run, Stop-Gap Medical Malpractice Liability Coverage. The state establishes its own insurance fund from which doctors can purchase insurance

⁹³ Ibid.

⁹⁴ *Issue Brief*; "Addressing the Medical Malpractice Insurance Crisis", Emily V. Cornell, National Governor's Association, December 5, 2002

if there is no other insurance carrier on the market. Typically overseen in the department of insurance and administered by a third party administrator, these funds try to relieve the immediate crisis and provide immediate relief to physicians unable to find affordable insurance. **Nevada** and **West Virginia** established state- based medical malpractice insurance funds in 2002 in order to relieve the current shortage.... The benefit of this type of fund is that it solves the immediate shortage of available insurance but not always of affordable insurance. In addition it is difficult to price premiums that are affordable without putting the state at risk for being the sole insurer in the state. In West Virginia, the state was required to price premiums higher than what was available in the commercial market in order to not compete with the commercial market.

- State Patient Compensation Programs. Patient compensation funds spread the cost of high awards more broadly. The state creates a fund that pays the portion of a judgment or settlement against a health care provider that exceeds a designated amount— such as \$200,000 per occurrence and \$600,000 annually. The fund pays the remainder of the award or it may have a maximum – such as up to \$1 million. The provider is responsible for awards beyond the funds' maximum unless a corresponding limit on medical liability applies. These funds are funded through an annual surcharge assessed against healthcare providers that participate in the fund, and participation can be mandatory or voluntary. Seven states—**Indiana, Louisiana, Nebraska, New Mexico, North Dakota, South Carolina, and Virginia**— operate voluntary systems, and three states—**Kansas, Pennsylvania, and Wisconsin**—operate mandatory programs. Since patient compensation funds help spread the risk more broadly, they help maintain the availability of medical malpractice insurance. However, it means that health care providers may pay two premiums for malpractice insurance, and therefore does not address the affordability issues.
- State Subsidies to Providers. The state establishes a mechanism that subsidizes all or a portion of the provider's insurance premium. This type of system could be set up as a one-time fund or continue for a limited number of years until insurance premiums stabilize. Subsidies could be made available to all providers, to a select group of providers who practice in high-risk specialties, or to providers in a select medically underserved geographical area within a state. Subsidies are simple to administer and easy to sell politically, especially if they are targeted to providers in a geographically underserved area. However, they do not address the underlying reason for high premiums. **Arizona, Hawaii, Illinois, Louisiana, Maine, Nevada, New York, North Carolina, Texas, and**

Washington have tried this approach in the past to solve an immediate crisis. These programs were established in the late 1980s and abandoned as the liability crisis abated.

- Joint Underwriting Associations. A Joint Underwriting Association (JUA) is a state sponsored association of insurance companies formed with statutory approval from the state for the express purpose of providing certain insurance to the public. JUAs are usually formed because the voluntary market is unwilling to write coverage. The advantage of a JUA is that it spreads the risk across several companies, instead of one. They may cease when the voluntary market becomes available for that line of business. JUAs address the lack of insurance. However, insurance from a JUA typically is more expensive than from the private market, since it is the insurer of last resort, particularly for high-risk specialties who have no other choice.
- Physician Insurer Associations or Physician Mutual. Physician insurer associations are physician owned and operated insurance companies that provide medical liability [insurance]. These insurance companies began in the 1970s during the first medical liability crisis. Doctors, with the support of medical and hospital associations, contributed their own funds as capital to start as many as 100 provider-owned specialty carriers across the country. They have been dubbed “bed pan mutuals” by their commercial competitors. Currently, physician insurance companies insure over 60 percent of the nation’s practicing physicians. Physician insurer associations create other carriers in the market to provide malpractice insurance and therefore address access to insurance for physicians. However, there is no indication that these types of insurance carriers are immune from the same issues that have driven out other commercial insurance carriers.
- State-Funded Indemnity for Specific Services. State-funded indemnity offers liability coverage for providers who typically have a relationship with the state-- either through the state university hospital or another type of public hospital system--and who provide critical emergency services. A state indemnity program typically covers a claim against a physician when the physician is working directly for a city, county or state and/or providing specific services such as trauma or obstetrical. The liability is shifted from the provider to the government, and all claims are brought against the state rather than the provider. This option address helps cover providers who serve low-income populations and target liability protections to the groups of providers that have been hardest hit. However, there is the risk that the state becomes the deep pocket in malpractice cases.

Another option, *captive insurers*, is not discussed in detail here. (A

captive insurer is so named because it is owned by the insureds.) Montana has adopted legislation authorizing the creation and operation of captive insurers, and several have been created. During the course of the study, several Montana hospitals were pursuing the creation of a captive insurance company for self-coverage.⁹⁵ Staff at the Office of the Insurance Commissioner confirm that the captive has been established.⁹⁶

Insurance Reform: California's Proposition 103

Aside from the insurance market interventions discussed above, there are other insurance reforms available to public policy makers. Prominently among them is Proposition 103-type reform. California's Proposition 103 is a 15-plus-year-old initiative composed of six primary elements. It:

- mandated an immediate rollback of rates of at least 20% – rate relief to offset excessive rate increases by establishing a baseline for measuring appropriate rates.
- froze rates for one year. Ultimately, because of the delay caused by insurance company legal challenges to Proposition 103, rates remained frozen for four years pursuant to decisions by the state's insurance commissioner.
- created a stringent disclosure and “prior approval” system of insurance regulation, which requires insurance companies to submit applications for rate changes to the California Department of Insurance for review before they are approved. Proposition 103 gives the California Insurance Commissioner the authority to place limits on an insurance company's profits, expenses and projections of future losses (a critical area of abuse).
- authorized consumers to challenge insurance companies' rates and

⁹⁵ Testimony of Claudia Clifford, Office of the State Insurance Commissioner, in *Minutes*, SJR 32 Subcommittee on Medical Liability Insurance, September 22, 2003.

⁹⁶ Communication with John Huth, Office of the Insurance Commissioner, September 2004.

- practices in court or before the Department of Insurance.
- repealed anti-competitive laws in order to stimulate competition and establish a free market for insurance. Proposition 103 repealed the industry's exemption from state antitrust laws, and prohibited anti-competitive insurance industry "rating organizations" from sharing price and marketing data among companies, and from projecting "advisory," or future, rates, generic expenses and profits. It repealed the law that prohibited insurance agents/brokers from cutting their own commissions in order to give premium discounts to consumers. It permits banks and other financial institutions to offer insurance policies. And it authorizes individuals, clubs and other associations to unite to negotiate lower cost group insurance policies.
 - promoted full democratic accountability to the public in the implementation of the initiative by making the Insurance Commissioner an elected position.⁹⁷

The proponents of Proposition 103 remain foursquare behind the initiative and, irrespective of California's MICRA⁹⁸, contend that:

... the most effective way to protect consumers and ensure reasonable insurance rates is through the tools of a prior approval insurance regulation system. Our research has shown that insurance company regulation, when properly implemented, can save consumers billions of dollars and maintain profitability within the insurance industry, thereby providing customers with the most choice in the market. In other words, the regimen of insurance regulation creates the environment that is most conducive to marketplace competition while also affording consumers necessary protection against insurance company profiteering....

⁹⁷ Excerpt from "Proposition 103: A Model for Insurance Regulation", Testimony of Douglas Heller, Foundation for Taxpayer and Consumer Rights, Before the Committee on Commerce, Science and Transportation United States Senate, Washington, D.C., October 22, 2003

⁹⁸ Medical Injury Compensation Reform Act of 1975 (California; MICRA 1975).

Proposition 103 worked. Insurance companies refunded over \$1.2 billion to policyholders, including motorists, homeowners and doctors. In the closely studied area of auto insurance, California was the only state in the nation in which auto insurance liability premiums actually dropped between 1989 and 2001, according to NAIC data. A 2001 study by the Consumer Federation of America concluded that the prior approval provision of Proposition 103 blocked over \$23 billion in rate increases for auto insurance alone through 2000.⁹⁹

Montana does not have statutory provisions similar to CA Proposition 103, but likely could enact something similar. A summary of Proposition 103 is included at Appendix D.

Other Potential Reforms

Testifying before Congress in October 2003 on behalf of the organization Public Citizen, Mr. Douglas Heller outlined seven discrete alternatives that would address some of the medical liability issues identified in SJR 32 and provide additional information or protection to the public. Heller's proposed reforms appear below.¹⁰⁰

Reform medical board governance States should sever any remaining formal, debilitating links between state licensing boards and state medical societies. Members of medical boards (and separate disciplinary boards, where present) should be appointed by the governor, and the governor's choice of appointees should not be limited to a medical society's nominees. At least 50 percent of the members of each state medical board and disciplinary board should be well-informed and well-trained public members who have no ties to health care providers and who, preferably, have a history of advocacy on behalf of patients. The governor should appoint members to the Medical Board whose top priority is protecting the public's health, not providing assistance to physicians who are trying to evade disciplinary actions.

⁹⁹ *Op. cit.*, Heller, p. 3.

¹⁰⁰ *Op. cit.*, Heller, Appendix A.

Beef up medical board funding and staffing. State legislatures should permit medical boards to spend all the revenue from medical licensing fees, rather than being forced to give part to the state Treasury. The medical boards should raise their fees to \$500 a year. All boards could benefit from hiring new investigators and legal staff. Boards should employ adequate staff to process and investigate all complaints within 30 days, to review all malpractice claims filed with the board, to monitor and regularly visit doctors who have been disciplined to ensure their compliance with the sanctions imposed, and to ensure compliance with reporting requirements. They should hire investigators to seek out errant doctors, through review of pharmacy records, consultation with medical examiners, and targeted office audits of those doctors practicing alone and suspected of poor care.

Require risk prevention. States should adopt a law, similar to one in Massachusetts, that requires all hospitals and other health care providers to have a meaningful, functioning risk prevention program designed to prevent injury to patients. Massachusetts also requires all adverse incidents occurring in hospitals or in doctors' offices to be reported to the medical board.

Require periodic recertification of doctors based on a written exam and audit of their patients' medical care records.

Institute experience rating. Doctors should be rated on performance for malpractice premiums. Doctors with numerous malpractice claims must be reviewed and higher premiums imposed so that they are discouraged from practicing and competent doctors do not subsidize them.

Spread the risk more broadly. The number of classifications of doctor specialties for insurance rating purposes should be reduced. Risk pools for some are too small and thus overly influenced by a few losses and the concentration in a few specialties of doctors handling the highest risk patients. Often the high-risk patients are "referred up" from general practitioners who do not bear any of the risk.

The Specific Case of Wisconsin and Medical Liability

On January 15, 2004, the SJR 32 Subcommittee asked its staff to prepare and present an overview of the Wisconsin Health Care Liability and Patients Compensation Act (HCLPCA or Act), enacted in 1975. The narrative that follows describes the primary components of the Act in a question-and-answer format. The statutory language of the Act is codified at Chapter 655, Wisconsin Statutes, and is available on line at <http://folio.legis.state.wi.us/>, then follow the links.

What is the Wisconsin HCLPCA? The Act is composed of two primary parts. One part establishes a liability environment for "health care" that is materially and procedurally different from Wisconsin's general liability environment. The other part establishes an environment for compensating patients who are injured as a result of malpractice that is materially different from Wisconsin's general liability environment.

The second part, the liability program established by the Act, is a mandatory excess insurance program that supplements but does not replace the existing, private, medical malpractice insurance marketplace. The program provides higher limits of liability insurance to health care providers and facilities than might otherwise be available or affordable. The liability program also requires and restricts certain actions by the parties affected by medical liability claims. In common parlance, these actions are referred to as "tort reforms".

The compensation program, manifested in the Patients Compensation Fund (PCF) and the processes associated with it, adds "capacity" to the liability insurance market and enables existing medical malpractice carriers to sell more policies. The logic underlying the program is: If the existing carriers do not have to allocate capital to sell higher limits of coverage, they can allocate that capital to sell more policies.

As briefly as is practical, the Act:

- establishes liability insurance requirements and restrictions on medical providers, medical facilities, and medical liability insurers;
- establishes requirements and restrictions on malpractice claimants, including their representatives and heirs;
- limits the remedy for malpractice exclusively to the provisions of the Act;
- establishes processes for making and resolving malpractice claims;
- establishes limits on attorney fees payable for malpractice claims;
- establishes procedures for the management, by a public entity, of compensation paid to a claimant for medical costs that result from malpractice by a medical provider or facility;
- imposes limits on noneconomic damages payable for malpractice;
- establishes procedures for setting fees to sustain and operate the patients compensation programs;
- disallows a medical practitioner or facility from rejecting a settlement agreed to by an insurer and claimant;
- precludes an insurer from cancelling or not renewing a liability policy, except in certain circumstances;
- requires medical liability insurers to file monthly reports on the details of each claim paid during the previous month;
- creates a "patients compensation fund" designed to compensate, in certain cases, certain claimants who have suffered from malpractice and to protect medical providers, facilities, and insurers from unusually large claims payments;
- establishes and provides for the administration of the Act, particularly the PCF;
- establishes processes for post-claim award review and mediation;
- requires various reports from various entities at various times for various purposes;
- establishes and provides for the administration of a "mediation fund", which essentially is an appendage of the Act.

Who is affected by the provisions of the Act? There are basically two categories of persons who are affected by the provisions of the Act. The first category includes all (except as described below) of the following in Wisconsin: physicians, nurse anesthetists, any partnership composed of physicians or nurse anesthetists, or both; any corporation organized and operated in Wisconsin for the primary purpose of providing the medical services of physicians or nurse anesthetists, or both; any cooperative sickness care association that operates a nonprofit sickness care plan in Wisconsin and that directly provides services through salaried employees in its own facility; any ambulatory surgery center that operates in Wisconsin; any hospital that operates in Wisconsin; any entity operated in Wisconsin that is an affiliate of a hospital and that provides diagnosis or treatment of or care for patients of the hospital; and any nursing home whose operations are combined as a single entity with a hospital, whether or not the nursing home operations are physically separate from the hospital operations. (However, this category does not include: a physician or a nurse anesthetist who is a state, county, or municipal employee, or a federal employee or contractor covered under the federal tort claims act and who is acting within the scope of his or her employment or contractual duties.) Participation by active Wisconsin providers is mandatory. There are some providers for whom coverage is optional, e.g., Michigan physicians doing substantial business in Wisconsin.

The second category is composed of: any person/patient (or representative of a person/patient) who received or should have received health care services from a health care provider or from an employee of a health care provider acting within the scope of his or her employment if the person makes a claim; or any spouse, parent, minor sibling or child of the person/patient, which spouse, parent, minor sibling or child of the person/patient has a derivative claim for injury or death on account of malpractice. All claims made are subject to the provisions of the Act.

Why was the program created? The program was created in 1975 as a response to the first medical malpractice insurance crisis. Events at that time disrupted the lives of physicians and the people they serve in ways similar to disruptions reportedly occurring nowadays in various jurisdictions.

Market disruptions that were occurring in the 1970s were likely due, in part, to economic conditions and to the tort system. Medical providers and facilities in Wisconsin and many other states had experienced a "hard" liability insurance market – providers and facilities could not afford or in some cases even buy the insurance they needed.

The market disruption was partially a result of the economic law of supply and demand. The insurance industry did not have the capacity to supply enough insurance at affordable prices to meet the needs of health care providers. The program was established to immediately expand access to insurance and to provide, in the longer term, a reliable source of insurance capacity.

How did the program create additional malpractice insurance capacity?

The program, through the PCF, is an excess insurance or reinsurance program. The PCF pays for claims that exceed a certain dollar threshold. By launching an insurance program to cover the high end of a claim, the state infused new capacity into the system. The program relieved the existing market of the pressure to reserve for the most expensive claims and, thus, additional capacity was created immediately in the existing market. Since inception in 1975, the PCF has continued to provide liability insurance capacity above what there would be absent the program.

What level of insurance coverage does the program provide? Under

Wisconsin law (April 2003), health care providers must obtain primary medical malpractice insurance from private insurance companies in the amount of \$1 million per occurrence and \$3 million per policy year in the aggregate. (A self-insured provider must have a minimum of \$800,000 of primary coverage.) The PCF provides coverage in excess of the primary insurance and PCF coverage is unlimited.

How does this program stabilize the medical malpractice marketplace?

The Wisconsin program initially provided an immediate increase in capacity and continues to provide some added level of capacity with respect to higher limits of coverage. The private market in Wisconsin is no longer wholly dependant on the ability of domestic and international reinsurers to provide excess coverage.

In the past, capacity for excess insurance was driven by economic conditions beyond Wisconsin's borders that cause fluctuations in the worldwide insurance marketplace. At times, reinsurers essentially dictated who primary insurers can cover, the prices primary insurers charge, and the coverage primary insurers provide. The PCF allows medical liability insurers and their insureds in Wisconsin to affect, at some level, pricing and coverage decisions.

Importantly, the primary effect (and goal?) of the program has been to increase the availability of liability insurance. The price of liability insurance, especially for primary coverage, is still market driven.

How is the Wisconsin PCF capitalized? Initially, the PCF was not capitalized. Rather, it operated on a cash basis during its first 5 years of existence. (The State of Montana's self-insured general liability insurance program currently operates on a cash basis.) During the 1980's, the PCF

switched from cash accounting to accrual accounting to improve the integrity of the fund. Under the accrual method, providers are assessed an amount that is based on estimates of what all claims would total over time for incidents that occurred in any given year, rather than on what the payout amount was for that year. Accrual accounting ensures that the PCF has sufficient assets to pay all outstanding liabilities, including claims incurred but not reported, if the PCF were discontinued. The estimates of what claims would total over time are actuarially determined. Wisconsin requires insurers to be financially solvent such that their assets are sufficient to cover any outstanding liabilities. Therefore, if an insurer stops doing business, all outstanding claims against the insurer will be paid. The PCF is currently operated in a similar manner.

Does the Wisconsin program affect the price of malpractice insurance? In total, the programs may affect liability insurance premiums but, ultimately, any effect on pricing may be unknowable. At best and to the extent that pricing is affected, which aspect(s) of the entire program accounts for which portion of any pricing effect is elusive.

The programs created by the Act are multi-faceted and include components about which some advocates and some opponents fundamentally disagree. For example, the Wisconsin program includes many elements that tort reform advocates hail as economically vital and that consumer advocates assail as false prescriptions or red herrings. The programs' other elements -- (medical) jurisprudence reforms, medical practice reforms, insurance reforms -- also have their own advocates and detractors and may or may not have incremental effects on MMLI pricing.

Is the program simply a bonus for special interests? Medical providers

and facilities and medical liability insurers are the most obvious and directly affected beneficiaries. To the extent that any of those groups is a "special interest", the program may be a bonus. However, to the extent that liability insurance and tort law affect access to and the cost of medical care, there are numerous others who benefit indirectly, with the potential that everyone who receives or merely has access to medical care in Wisconsin receives some residual bonus. Consequently, distinguishing the special interests from within the general interest is both personal and difficult.

On the flip side of the special interest coin, persons injured through medical negligence may be denied something perceived to be "full compensation" for the negligent acts of medical providers or facilities. Reinsurers may miss out on lucrative business. Attorneys may forego income due to caps on contingency fees. Medical providers and facilities forego their freedom of choice regarding excess liability coverage, both from whom it is purchased and at what level of coverage. The insured, the insurers, and injured persons are all compelled to follow laws and procedures that they may not particularly like or believe in, and so on.

How financially healthy or stable is the PCF? According to a report from the Wisconsin Legislative Fiscal Bureau staff,¹⁰¹ the PCF had approximately \$588 million in assets and about \$582 million in estimated liabilities at the end of fiscal year 2002. The report also stated that the amounts contemplated to be payable for current-but-unsettled claims and future claims had historically exceeded actual claims by a significant amount. That fact has also caused the Board of Governors of the PCF to regularly set annual assessments for providers and facilities at levels

¹⁰¹ *Patients Compensation Fund*, Paper #458, by Kim Swissdorf, Wisconsin Legislative Fiscal Bureau, April 23, 2003.

considerably less than the amounts recommended by the actuary. In the most recent year reported, the actuary had recommended an increase of 117.4%, but the Board set the increase at only 5%.¹⁰² (Of the nine fiscal years from 1994-95 through 2002-03, the Board commonly set assessments 10 percentage points or more below the levels advised by the actuary.) Considering the PCF had, at FY 2002 year end, a positive equity of ~\$6 million, particularly, given previous Boards' actions in setting assessments, it appears that the PCF is relatively healthy and stable.

Are the citizens of Wisconsin on the hook to pay claims? As the program is designed statutorily, Wisconsinites are not on the hook to pay claims. The legal framework of the program has created, ostensibly, a quasi-private insurance entity that is removed from direct agency with the State of Wisconsin. The entity does not act as an agent of the state (as would a Department of Health employee, an elected official, or a contractor in their official capacity) and, theoretically, should not legally be treated as an agent of the state.

However, the State of Wisconsin, through the Board of Governors and the Insurance Commissioner each acting in their statutory capacity, is a party to the programs. Because the programs are a creation of the state, there may be at least a moral obligation for the state, i.e., taxpayers, to pay for outstanding liabilities if the PCF is ever unable to pay.

Is the Wisconsin approach unique? In many ways, no; in some ways, yes. According to the Wisconsin Legislative Fiscal Bureau, there are eight states, plus Wisconsin, that have some type of a PCF.¹⁰³ Of the nine

¹⁰² Ibid., p. 5.

¹⁰³ Ibid, p. 4.

"PCF states", participation by providers and facilities is mandatory in Kansas, Pennsylvania, and Wisconsin. Coverage is unlimited in South Carolina and Wisconsin. Wisconsin's primary coverage requirements of \$1 million per incident and \$3 million per policy year are higher than any of the other PCF states. Finally, Wisconsin is the only state that has both a mandatory participation requirement and unlimited coverage.

What options have other states pursued? Variations of the Wisconsin model include the ways in which liability coverage is provided and compensation is meted out and who manages the programs and how, to name only a few.

The "liability coverage" options include: whether the state's program is optional or mandatory; the coverage limits, e.g., \$1 million/\$3 million; and the allocation of the costs of the program, i.e., participants are assessed proportionately, uniformly, or by some other measure.

The potential processes to determine the amount of PCF compensation provided by programs include: "no fault" compensation (akin to workers' compensation); voluntary arbitration; mandatory arbitration; medical malpractice courts; various mechanisms for appeals; and others.

The options for determining the amount of compensation include: PCF coverage for a fixed-dollar maximum amount, e.g., the amount of the claim above the insured's private-policy maximum up to a maximum amount, e.g., \$1 million; PCF coverage for a fixed-percentage maximum amount, e.g. 50% of the amount of the claim above the insured's policy maximum up to a maximum amount, e.g., \$1 million; for unlimited PCF coverage above the insured's private-policy maximum; combinations of the above.

The options for managing the programs would include: variations of the independent "board" and "council" approach that Wisconsin uses;

attaching PCF program management to an existing entity (for example, the board of the state compensation insurance fund); establishing a new state entity in or assigning PCF program management to an existing state entity in the Executive Branch (for example, an office of insurance regulation); establishing an elected office, either an individual or a commission, to manage the program; or a combination of these or other alternatives.

The LC 5000 Option

The Subcommittee invested considerable time and energy in adapting the concepts contained in Wisconsin Health Care Liability and Patients Compensation Act into a form that can work for Montana. Ultimately, the Subcommittee settled on and recommends LC 5000.

LC 5000 deviates from the Wisconsin HCLPCA in at least two substantial ways. First, LC 5000 does not require doctors, hospitals, or other providers of medical care to carry any amount of primary liability coverage. Primary coverage is optional, at each provider's discretion. (Wisconsin requires minimums of \$1 million/\$3 million in primary coverage.) Second, LC 5000 sets \$500,000 as the threshold at which the Plan provides coverage for damages.¹⁰⁴ (The threshold in Wisconsin is \$1 million in damages.)

Another significant distinction between the Wisconsin HCLPCA and LC 5000 is the cap on noneconomic damages. In Wisconsin, the limit is adjusted annually for inflation based on the consumer price index. In LC 5000, the \$250,000 cap established by House Bill No. 309 (1995) remains

¹⁰⁴ From conversations between Sen. John Cobb and the author, the author infers that each of these provisions was proposed with the beliefs that the prices paid by medical providers for MMLI will be less than current prices; that the prices paid for MMLI will be more stable in the future, and that the availability of MMLI will be expanded.

intact and constant.¹⁰⁵

Summary of Montana MMLI Law, Other State's MMLI Laws, and Options

Montana has enacted various tort reforms over the past 20 years that place the state among the elite with respect to medical liability statutes. Even as California' MICRA is sometimes referred to as "The Gold Standard", Montana's law is substantially the same.¹⁰⁶ Furthermore, if Montana is at or nearly at the gold standard of tort reforms, it should be difficult to conclude or argue that the status of Montana's tort law can have had anything but a *positive* effect on medical liability premiums and the availability of medical liability insurance. Particularly with respect to premiums, however, it is difficult to articulate with any degree of confidence just what positive effects have resulted.

Aside from tort reform, different students of the medical liability insurance "crises" have identified or proposed various alternatives as partial solutions. These alternatives include variations on elements of tort law; educating judges and juries; creating a specialized court; implementing tools for normalizing jury awards; several different approaches for "alternative dispute resolution"; no-fault liability; establishing clinical practice guidelines; several insurance market interventions; Proposition 103-type (CA) requirements, restrictions, and authority; reforming the state medical board; enhancing the existing medical board and its staff; requiring risk prevention and periodic recertification of doctors; instituting experience ratings in medical liability

¹⁰⁵ "Constant" is used here in the context that law is constant unless changed through the legislative process.

¹⁰⁶ For a more detailed comparison, see Appendix C, "California vs. Montana: Detailed Comparison of Major Legal Provisions Related to Medical Malpractice" (Source: Medical Malpractice Summary, McCullough, Campbell & Lane, 205 North Michigan Ave., Suite 4100, Chicago, Illinois 60601-5925).

insurance practices; and spreading the risk of medical liability more broadly. All tolled, there are at least a couple dozen options listed herein that have been enacted by, considered in, or proposed to various states' legislatures. There are likely to be many others.

Fundamentally, policymakers must determine to their own satisfaction the cause(s) of rising medical liability insurance premiums and, if it exists in Montana, declining availability of medical liability insurance. Only then can they enact public policies to remedy the concerns and problems.

CHAPTER 4 A Measure of Success

Too frequently and most unfortunately, work done by interim committees is sometimes dismissed out of hand, particularly by those who are ignorant of a committee's efforts or those who may feel their ox was somehow gored as a result of the committee's actions. Although some similar carping may be directed at the work of the Subcommittee, any such comments can't legitimately be based on a contention that the Subcommittee "didn't do anything".

To the contrary. The Subcommittee attempted diligently to address each of the issues identified in SJR 32:

- the rising cost of liability insurance for health care providers;
- a significant decline in the past few years in the number of insurance carriers that provide liability insurance for hospitals, clinics, and nursing homes;
- the hypothesis that dramatic hikes in the prices paid by hospitals, clinics, and nursing homes for liability insurance may be a major contributor to the escalation in the cost of providing medical treatment;
- the theory that increased premiums for liability insurance may be forcing physicians and other providers in Montana to consider curtailing certain medical services;
- that the State of Montana has a compelling interest in ensuring that affordable health care is available for its citizens, and a contention that stabilizing premiums for liability insurance for health care facilities and health care providers associated with health care facilities will contribute toward cost containment for health care for Montana citizens.

The study committee was also directed by SJR 32 to compile information seen to be relevant by the Legislature and to:

- review measures adopted by other states to address the liability insurance problems related to liability insurance for health care facilities and health care providers associated with health care facilities;
- identify or propose strategies for increasing the availability of affordable liability coverage, including alternative sources of liability coverage;
- identify factors affecting the cost of liability insurance for health care facilities and health care providers associated with health care facilities; and
- identify or develop strategies for resolving liability claims outside of the court system.

This chapter reviews information provided to the Subcommittee with respect each of the issues identified and legislature's directions in SJR 32 and briefly describes the Subcommittee's recommendation to each issue and information compiled and reviewed.

The rising cost of liability insurance for health care providers

There is little doubt that MMLI premiums have increased in Montana in recent years, accelerating considerably in the last 2-3 years.¹⁰⁷ The factors affecting the cost of liability insurance are numerous, sometimes complex, often intertwined, and strenuously debated. Several of the cost factors get the bulk of attention, including tort laws affecting medical providers and malpractice claimants, declining competition due to fewer insurers or other factors, explosions in the number of medical malpractice

¹⁰⁷ "Detail Business in the State" (1998-2003 series) , State Insurance Commissioner, Helena, MT, and testimony to the SJR 32 Subcommittee.

claims and jury awards stemming from the claims, the cyclical nature of the insurance business, and declines in investment income. The Subcommittee reviewed each of these front page factors, as well as others.

Medical Liability Statutes

In the main, the legal environment surrounding and underpinning medical liability is often pointed to by insurers and their insureds as a cause of rising premiums. That theme was evident in the testimony from doctors across the state.¹⁰⁸ In Montana, recent Legislatures have significantly revised code provisions by enacting California's MICRA-type reforms to improve this state's legal environment. Because Montana's medical liability statutes have, since 1995, reflected nearly all of the provisions advocated by the liability insurance industry, state and national medical associations, doctors and others testifying before the Subcommittee, numerous radio and television talk show wags, and other tort reform advocates, it is debatable whether additional tort reforms can or will visibly affect MMLI premiums in Montana.

However, to the extent that the Subcommittee could identify additional statutory reforms to further improve the medical liability environment in Montana, the members examined and reviewed several options and recommend LCs 5001, 5002, 5004, 5005, 5007, and 5008. (See Appendix A.)

Declining Competition From Fewer Providers

Competition among MMLI providers in Montana may have declined for a number of reasons, but competition cannot have faded as the result of a

¹⁰⁸ See *Minutes*, SJR 32 Subcommittee on Medical Liability Insurance, November 16-17, 2003, et. seq.

decrease in the raw numbers of insurers licensed to sell MMLI or actually selling MMLI and collecting premiums. As illustrated in Chapter 2, the number of insurers licensed to sell and the number of insurers selling MMLI in Montana has remained essential the same for the past 6 years at least.¹⁰⁹ Because the current crisis first emerged only 3 years ago or less, fewer Montana insurers cannot be a reason for diminished competition.

Explosion in Malpractice Claims

Every claim of medical malpractice in Montana must, by statute, be reviewed by the Montana Medical Legal Panel. Therefore, records maintained by the Panel should be a definitive source of data regarding the number of claims filed. According to testimony from staff of the Panel,

...in an absolute sense, the rate of claims and the rate of cases filed are both diminishing in Montana. In 2000, Montana had a total of 93 paid claims, as reported by the National Practitioner Data Bank. In 2001, Montana had 67 paid claims and in 2002, Montana had 69 paid claims.¹¹⁰

The absolute number of claims filed annually has remained relatively stable since 1995 at about 175 claims per year.¹¹¹ Whether computed on a per 1,000 physician basis or a per 1 million population basis, the trend of the rate of physicians involved in claims has been steadily-decreasing for the past decade.¹¹²

¹⁰⁹ Ibid.

¹¹⁰ Taken from the *Minutes*, SJR 32 Subcommittee on Medical Liability Insurance, Nov. 17, 2004, pp. 13-16.

¹¹¹ Table showing "Montana Physicians Involved in Medical Malpractice Claims" in *2004 Annual Report of the Montana Medical Legal Panel*, p. 10. The fewest claims was 158 (1999), the most was 203 in 1995.

¹¹² *2004 Annual Report of the Montana Medical Legal Panel*, p. 10.

At 19 per 1,000 doctors in active practice, Montana also compares favorably on a national basis in the number of lawsuits.¹¹³ Nationally, the average rate is about 145 lawsuits per 1,000 doctors.¹¹⁴ Of the 18 states for which data were reported, Montana ranked lower in lawsuits per 1,000 than all but Connecticut (16/1000) and Minnesota (10/1000).¹¹⁵

Finally, at meeting after meeting, doctors repeatedly and uniformly testified that they, personally, had not had a medical malpractice claim filed recently (10 years), if ever.

From the information provided to the Subcommittee, it was fairly clear that Montana has not seen an explosion in the nominal number of claims and, in fact, has experienced a decline in the relative number of claims in recent years.

Explosion in Jury Awards

With respect to changes in the severity of jury awards in Montana, it is very difficult to reach any objective conclusion. Nominal amounts awarded by juries are increasing and logically should be, particularly because the bulk of jury awards in Montana are for actual damages that include, primarily, lost wages and future medical expenses.¹¹⁶ Therefore, without knowing the specifics of each case and the nature and scope of each award, including the factors considered in making the award, just comparing jury awards could be merely academic. Concluding that awards have "exploded" without considerable, detailed documentation would be, at best, inadvisable.

¹¹³ Table showing "Medical Liability Lawsuits Against Physicians Number Of Lawsuits Per 1,000 Physicians" in *2004 Annual Report of the Montana Medical Legal Panel*, p. 16.

¹¹⁴ Ibid.

¹¹⁵ Ibid.

¹¹⁶ The literature and testimony both gave examples of injuries that would have been fatal not long ago but from which the victim might these days be saved, only to face expensive therapy and rehabilitation for years to come or succumb to decades of life in a nursing home.

To their credit, insurers provided the Subcommittee with selected financial data showing paid losses, incurred losses, earned premiums, direct premiums earned, net premiums earned, and loss ratios, among other information.

But insurers have income in addition to earned premiums and they incur expenses other than direct losses and particularly direct losses from jury awards. Settlement amounts, actual versus noneconomic losses, income from sources other than direct premiums earned, changes in expenses other than direct losses, experience and expectations regarding changes in medical costs and wages, and other data are clearly necessary if the whole picture is to be seen and appreciated. Therefore, a conclusion regarding exploding severity is elusive and perhaps unknowable at this time because of the lack of useful, readily available data.

Nevertheless, the Subcommittee heard testimony that jury awards, and by implication or assertion, courts too were getting out of control. A representative of The Doctors Company (TDC) testified,

In the years immediately following the enactment of Montana medical tort reform statutes [1995], we observed a notable decline in Montana claims severity, but this picture has, unfortunately, reversed. While difficult to pinpoint, we attribute the sharp rise in claims costs to medical cost inflation, increasingly liberal court awards, and societal norms relating to litigiousness and entitlement.¹¹⁷

Similarly, a representative of the Utah Medical Insurance Association (UMIA) testified that premiums for Montana's doctors and hospitals were

¹¹⁷ Testimony of Richard E. Anderson, MD, Chairman, The Doctors Company, in *Minutes*, SJR 32 Subcommittee on Medical Liability Insurance, January 15, 2004, Exhibit #4, p. 5.

likely to continue to increase "without changes in the case law."¹¹⁸ The implication was clearly that the severity of damages awarded through litigation had been increasing and, absent changes, UMIA anticipated further increases. Unfortunately, neither the UMIA nor TDC presented detailed documentation specific to jury awards.

The insurance cycle

The Subcommittee received information and testimony that at least part of the increase in MMLI premiums is likely due to the cyclical nature of the MMLI business. For example,

Insurers make most of their profits from investment income. During years of high interest rates and/or excellent insurer profits, insurance companies engage in fierce competition for premium dollars to invest for maximum return. Insurers severely underprice their policies and insure very poor risks just to get premium dollars to invest. This is known as the "soft" insurance market. But when investment income decreases — because interest rates drop or the stock market plummets or the cumulative price cuts make profits become unbearably low — the industry responds by sharply increasing premiums and reducing coverage, creating a "hard" insurance market.... A hard insurance market happened in the mid-1970s, precipitating rate hikes and coverage cutbacks, particularly with medical malpractice insurance and product liability insurance. A more severe crisis took place in the mid-1980s, when most liability insurance was impacted. Again, in 2002, the country experienced a "hard market," this time impacting property as well as liability coverages with some lines of insurance seeing rates going up 100% or more.¹¹⁹

¹¹⁸ Testimony of Martin Osowski, Utah Medical Insurance Association, in *Minutes*, SJR 32 Subcommittee on Medical Liability Insurance, January 15, 2004, p. 12.

¹¹⁹ *Op. cit.*, Medical Malpractice Insurance: Stable Losses/Unstable Rates 2003, "Exhibit 1: The Insurance Cycle", p. 4.

Information, provided by TDC and UMIA, confirmed that description and showed that both companies were loath to increase rates during the 1990s. Their reluctance reversed, however, quickly and drastically in conjunction with and following the declines in the financial markets beginning in 2000.¹²⁰

Declining investment income

As with several of the other issues, there is considerable disagreement about the effect of declining investment income. Insurance reform advocates point to the bursting of the "tech bubble" in early 2000 as coinciding with the emergence of the current insurance crisis. Insurance reform opponents shun that argument, declaring and documenting that liability insurers have the bulk of investable assets squirreled away in cash, money market funds, and high quality bonds. No less of an authority that the U.S. General Accounting Office concluded,

Insurers' losses, declines in investment income, a less competitive climate, and climbing reinsurance rates have all contributed to rising premium rates. First, among our seven sample states, insurers' losses have increased rapidly in some states, increasing the amount that insurers expect to pay out on future claims. Second, on the national level insurers' investment income has decreased, so that insurance companies must increasingly rely on premiums to cover costs. Third, some large medical malpractice insurers have left the market in some states because selling policies was no longer profitable, reducing the downward competitive pressure on premium rates that existed through most of the 1990s. Last, reinsurance rates

¹²⁰ "Detail Business in the State" (1998-2003 series) , State Insurance Commissioner, Helena, MT, and testimony of Martin Oslowski, Utah Medical Insurance Association, in *Minutes*, SJR 32 Subcommittee on Medical Liability Insurance, January 15, 2004.

for some medical malpractice insurers in our seven sample states have increased substantially, increasing insurers' overall costs. In combination, all the factors affecting premium rates and the availability of medical malpractice insurance contribute to the medical malpractice insurance cycle of hard and soft markets.¹²¹

In the final analysis, one could conclude that declining investment income was and continues to be a contributing and, perhaps, significant factor to increasing MMLI premiums. Unfortunately, there is little if anything that state policymakers might do to change that fact.

Linking rising MMLI premiums and rising costs of medical care

This is another case of "absolutely contradictory information by both sides, [where] sorting out the reality and fact is difficult"¹²² -- at least without looking beyond mere statements of fact. For example, the American Medical Association states that medical liability costs add \$60 billion to \$108 billion to the costs of health care each year.¹²³ In the words of Sen. Everett Dirksen, that's talking "real money".

By contrast, the group Americans for Insurance Reform states,

Medical malpractice payouts are less than one percent of total U.S. health care costs. All "losses" (verdicts, settlements, legal fees, etc.) have stayed under 1% percent for the last 18 years. In 2002,

¹²¹ *Medical Malpractice Insurance: Multiple Factors Have Contributed to Increases Rates*, U.S. General Accounting Office, June 2003, (GAO-03-702), p 15.

¹²² Telephone conversation with John Miller, Staff, California Senate Office of Research, September 2003.

¹²³ "Medical Liability Talking Points", American Medical Association, March 2004, on the Internet at URL <http://www.ama-assn.org/ama/pub/category/6087.html>. The figures are attributed, in the document, only to "U.S. Department of Health and Human Services, July 2002."

payouts were less than one percent (0.38%). Medical malpractice premiums are less than one percent of total U.S. health care costs. Dropping for nearly two decades, malpractice premiums have stayed below 1% of health care costs. In 2002, premiums were less than one percent (0.58%).¹²⁴

For starters, let us trust that the statements of both the Americans for Insurance Reform and the AMA are truthful.

Accepting the AMA figures at face value, each Montanan in 1998 sustained from \$204 to \$267 annually in medical liability costs¹²⁵ and the state as a whole carried somewhere between \$185 million and \$334 million in medical liability costs.¹²⁶ Those amounts can be translated into 6.4% to 11.5% of the total expenditures for health care in Montana.¹²⁷ According to 2002 figures captured by the State Insurance Commissioner, aggregate MMLI premiums of \$22.9 million plus all incurred losses of \$34.6 million totaled about \$57.5 million. Therefore, the \$130 million to \$200 million in medical liability costs unaccounted for must be hidden costs.

Accepting the Americans for Insurance Reform figures in the same vein as the AMA's figures, insurance premiums in Montana for 1998 should have been approximately \$16.24 million (0.58% x \$2.918 billion¹²⁸),

¹²⁴ "Think Malpractice is Driving Up Health Care Costs? Think Again.", undated, online at Americans for Insurance Reform, URL <http://www.insurance-reform.org/>.

¹²⁵ Staff estimate by dividing the total medical liability costs of \$60-\$108 billion by 294 million people, the U.S. population from the 2000 Census.

¹²⁶ The per Montanan cost, low and high, multiplied by 910,000 Montanans.

¹²⁷ Figures for total health care expenditures for Montana, \$2,918,000,000, are from State Health Facts Online at the Kaiser Family Foundation website, URL <http://www.statehealthfacts.kff.org/>.

¹²⁸ State Health Facts Online at the Kaiser Family Foundation website, URL <http://www.statehealthfacts.kff.org/>.

and were about \$16.5 million,¹²⁹ and all "losses" should have been about \$11.1 million (0.38% x \$2.918 billion), but were actually closer to \$16.1 million.¹³⁰ By these calculations and Americans for Insurance Reform figures, MMLI as a business should have netted about \$5.1 million in Montana in 1998, but reported an excess of premiums over losses of only about \$0.4 million.

What we *know* from published data is that MMLI premiums in 1998 were about \$16.5 million.¹³¹ We also know that total health care expenditures in Montana in 1998 were about \$2.92 billion. The total 1998 premiums divided by total 1998 personal health care expenditures is approximately 0.57%. The aggregated premiums *plus* incurred losses totaled about \$32.6 million, approximately 1.1% of total health care expenditures in 1998.

We also know that MMLI premiums in 2002 were about \$22.89 million and total incurred losses were approximately \$34.6 million (or 0.86% of total health care costs).¹³² Totaled, premiums plus losses for 2002 were about \$57.5 million (or 1.42% of total health care costs).

From information presented previously,¹³³ medical inflation averaged about 6.7% between 1990 and 2001. Applying that growth rate to the 1998 figure of \$2.92 billion for total health care expenses, a reasonable estimate of the same expenditures in 2003 could be \$4.03 billion. That

¹²⁹ "1998 Detail Business in the State", State Insurance Commissioner, Helena, MT Office of the Insurance Commissioner reports.

¹³⁰ Ibid.

¹³¹ "2002 Detail Business in the State: Medical Malpractice", State Insurance Commissioner, Helena, MT.

¹³² "2002 Detail Business in the State: Medical Malpractice", State Insurance Commissioner, Helena, MT.

¹³³ "Commentary: A Second Opinion on the Malpractice Plague", by Lorraine Woellert, *BusinessWeek online*, March 3, 2003.

suggests an increase in total expenditures for medical care in Montana from 1998 to 2003 of about \$1.1 billion. On a percentage basis, aggregated premiums plus incurred losses as a proportion of total health care expenditures may have grown to about 1.42%. That compares to 1.1% in 1998, an increase of 0.31% over the 5 years or about 0.06% annually.

The short of it is that total health care expenditures in Montana may have grown from about \$2.92 billion only 6 years ago to about \$4.03 billion last year, an increase of more or less \$1.12 billion. The increase in Montana MMLI premiums over the same time period is about \$9.8 million. The difference between the increase in total health care expenditures and the increase in total MMLI premiums is about \$1.1 billion. Of that increase, MMLI premium growth accounted for 0.88% of the growth, less than 1 penny for each dollar spent on health care.

Based on these figures, it is difficult to conclude that increases in MMLI premiums have had any discernable effect on the escalating costs of medical care. As a corollary, it is also difficult to support the premise that stabilizing premiums MMLI could contribute in any meaningful amount toward cost containment for health care for Montana citizens.

The effects of MMLI premiums on medical practice

The literature is full of anecdotes about doctors moving their practices from one state to another, about other doctors retiring early, about doctors practicing defensive medicine, and about communities in which there is no longer a doctor who will deliver babies, but perhaps several who used to.

Testimony given to the Subcommittee repeated many of the same warnings: disappearing access; practices and doctors moving across state

lines; early retirements; and so on.¹³⁴ There was no indication given by any of the witnesses that the warnings were not legitimate or the effects of the actions imminent.

However, there have also been investigations to determine the accuracy of similar stories in other jurisdictions, some of which have found little supporting evidence. Again relying on the GAO:

... we also determined that many of the reported provider actions taken in response to malpractice pressures were not substantiated or did not widely affect access to health care. For example, some reports of physicians relocating to other states, retiring, or closing practices were not accurate or involved relatively few physicians. In these same states, our review of Medicare claims data did not identify any major reductions in the utilization of certain services some physicians reported reducing because they consider the services to be high risk, such as certain orthopedic surgeries and mammograms.¹³⁵

The possibility that doctors will reduce services, move their practices, retire, or take some other action on the basis of increasing MMLI premiums must be viewed as real. The ability of policymakers to affect any such choice is much less clear.

Strategies to increase the availability of affordable liability insurance

The Subcommittee worked painstakingly at identifying avenues to increase the availability and affordability of MMLI. Most of Chapter 2

¹³⁴ *Minutes*, SJR 32 Subcommittee on Medical Liability Insurance, November 16-17, 2003, *et. seq.*

¹³⁵ *Medical Malpractice and Access to Health Care*, U.S. General Accounting Office, August 2003, (GAO-03-836), p. 5.

discusses some of the options considered. Ultimately, the Subcommittee recommends six bills -- LCs 5001, 5002, 5004, 5005, 5007, and 5008 -- to further reform Montana's medical liability laws, i.e., tort reforms, and two other bills -- LCs 5000 and 5009 -- to establish or allow alternative insurance products.

It is the hope and belief of the Subcommittee that in combination or individually the recommended bills will help to alleviate the perceived unavailability of MMLI in Montana or mitigate the recent rates of increases in MMLI premiums, or both.

Resolving liability claims outside of courts

Montana has the Montana Medical Legal Panel for over 25 years. Testimony given to the Subcommittee by both trial lawyers and defense attorneys uniformly praised the objectives, the functioning, and the outcomes of the Panel. It is viewed by legal practitioners and a bona fide success.

In contrast, many doctors testified that the Panel is an exercise in the infliction of anxiety. Some recounted unbearable stresses associated with the Panels, others complained that a Panel vote favoring the doctor was rarely heeded by the claimant. Still others viewed the Panels as little more than a thinly veiled opportunity for trial lawyers to preview the strength of the doctor's evidence or defense strategy.

In the end, the Subcommittee agreed that Panels effectively serve the purposes for which they were created -- a screening tool to weed out frivolous claims; a venue for claimants and defendants alike to receive an objective assessment of the claim; an opportunity for a claimant to confront the individual(s) whom the claimant believes did him or her harm -- and chose not to recommend revising the Panels.

The Subcommittee also considered other, nonjudicial alternatives, including voluntary and mandatory arbitration, both binding and nonbinding. In light of the perceived success of the Montana Medical Legal Panel, however, the Subcommittee did not pursue arbitration.

What caught the Subcommittee's attention was a proposal to allow a doctor or other medical provider to face a claimant and offer an act of or words of benevolence and protect the medical provider from the act or statement from being used as evidence in a civil action for medical malpractice.

Testimony revealed that some medical providers, both individuals and institutions, often desire to express an apology, fault, sympathy, compassion, etc., for the pain, suffering, or death of a person in their care. However, in such instances health care providers are typically advised by legal counsel to refrain from such expressions for fear that the expression will be proffered as evidence of an admission of liability.

Recognizing a potentially perverse consequence from a sincere act of grace and an opportunity to eliminate the potential, the Subcommittee recommends LC 5007. The Subcommittee also concluded that an act of benevolence as characterized in LC 5007 might be sufficient to satisfy the needs of a claimant and, thus, sees the bill as an opportunity to further reduce litigation.

Summary and Conclusion

For the better part of a year, the members of the SJR 32 Subcommittee on Medical Liability Insurance diligently studied the many facets of medical liability insurance. They read countless pages of reports, articles, essays, opinions, audits, bills, program designs, tables and graphs, and similar documents. They listened to hours of

presentations and testimony, some face to face, other through video conferencing technology. They learned of the history of liability or tort reforms, particularly in Montana, and the status of Montana's laws and legal precedents as developed in recent years.

Ultimately, they engaged in discussions about the causes of medical liability insurance problems -- rapidly increasing premiums and declining availability -- and about policy options designed to address the causes and thereby alleviate the problems. They considered more than 60 ideas, requested that draft legislation be prepared to encompass 10 of those ideas, and recommend eight of the ideas proposed as the draft bills contained in Appendix A.

Having dutifully fulfilled the charge given to them by the Legislative Council, the Subcommittee respectfully submits this document as its final report and recommends the draft legislation contained in Appendix A.

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